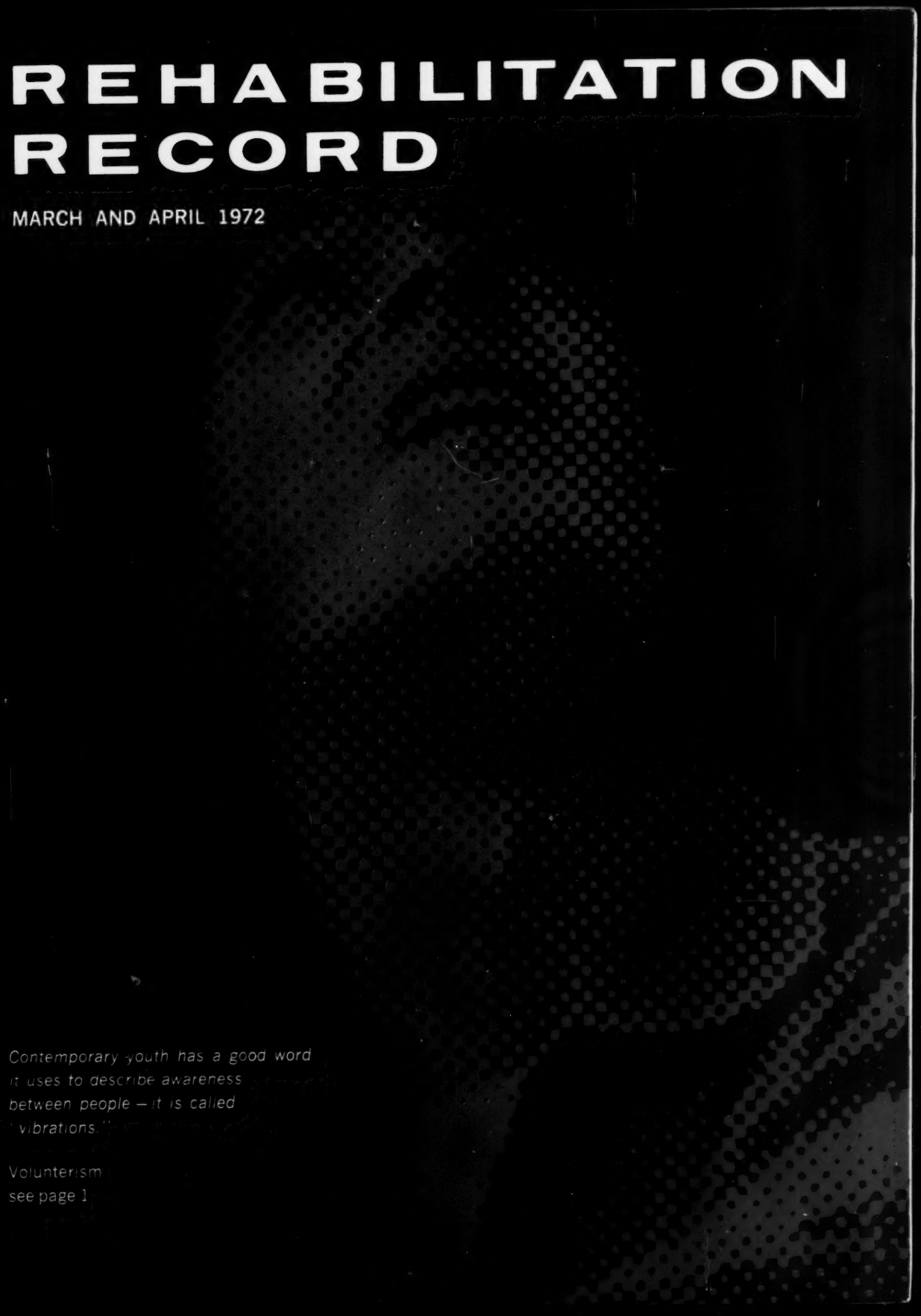
REHABILITATION RECORD

MARCH AND APRIL 1972



Contemporary youth has a good word it uses to describe awareness between people — it is called "vibrations."

Volunterism
see page 1

VIVE LA DIFFERENCE

In my travels about the country to various rehabilitation agencies and in talking with counselors, administrators, and agency leaders, the topic of service delivery is one that invariably occurs. We talk about "systems," and "programs," and "trends." We discuss caseloads and priorities, on the one hand, and quantity and quality rehabilitations, on the other. We search for "workable models."

In reviewing many of these encounters, the thought struck me that one aspect of "people processing" almost always recurs. Essentially it is that yesterday's impossibility is today's fact. In essence, the idea was, for instance, that a mentally retarded person was a public maintenance charge to be relegated to the back wards of institutions—safely out of view. Gradually, these people worked their way out of the back wards, out of the institutions, out into public view. Their story is astounding! Now, mentally retarded persons are performing effectively in a whole variety of jobs, from rudimentary to quite complex, in some cases. This story of the mentally retarded has its counterbalance in most disabling conditions—the epileptic, the quadriplegic, the cerebral palsied, and more.

But again, these are "group trends." I think that throughout rehabilitation's history there have been individual placements that, for one reason or another, could have been termed "placements before their time." Not long ago, one of our regional officials who had been a State VR employee for many years told me a fascinating story of a blinded veteran in California who is successfully running an 80-acre cattle ranch. He knows every inch of the spread. He manhandles cattle into the stocks as well as any buckaroo. He even carries a hoe handle (instead of a white cane) to "do in" rattlesnakes by sound rather than by sight. This same person told me of a homebound California woman who not only operated a small 3M business but ran a booking agency for topless dancers!

If you've had exceptional placements, we'd like to hear about them—in about 250 words (normally, one double-spaced, typewritten page). We'd be happy to share selected cases with our readers from time to time. The criteria that the editor will use are: 1) an unusual or innovative placement, 2) the above-mentioned space limitation, and 3) general interest.

Edward Newman

Commissioner

VOLUNTEERISM: Reawakening to an Age-Old Truth

Diane S. Roupe

A young student from University of Illinois enjoys a nature talk with group of retarded girls. From their expressions, the girls are enraptured, too.

MANKIND is in the process of rediscovering the master cure for all social and political afflictions. It is not new. It is as old as the universe; its potency will not diminish throughout eternity. The cure is: *mutual care and help* rooted in unselfish motivations. It is a concept which is known to all people. In fact, those who believe in the cumulative knowledge of humanity believe that knowledge of this Truth is intrinsic to every human soul.

Nevertheless, while acknowledging the significance of mutual helpfulness, and even lending a fair amount of verbal and written support for its attributes and possibilities, man has been increasingly ignoring the concept in his personal life and in his institutions of government, education, business, welfare, and other social services.

When the scribes of tomorrow evaluate our present society in the annals of time, they may deem our greatest evolutionary accomplishment to be the GREAT REAWAKENING TO THE NECESSITY OF HELPING ONE ANOTHER. This reawakening is a dynamic

Mrs. Roupe is chairman, Volunteers in Rehabilitation Project, Goodwill Industries of America, Inc.

Charm and personal development class conducted at Dallas Goodwill Industries. The classes are led by volunteers to the Woman's Auxiliary. Personal grooming instills pride and poise in the women who take the course.

social movement which is beginning to take hold in this country, and for that matter, in many other parts of the world. We call the concept "volunteerism." While the words "volunteer," "voluntarism," and "voluntaryism" have appeared in our dictionaries for years, the word "volunteerism" has not yet been included. Call it what you will. Understanding it, feeling it, and doing something about it is what counts. It means caring about and helping our fellow man without monetary compensation.

Contemporary youth has a good word it uses to describe awareness between two people—it is called "vibrations." We need to let ourselves feel the vibrations which exist between all human beings. We need to unshackle ourselves of false pride and admit that, as human beings, we can really do nothing "alone." The universe is, by nature, interdependent. This fact seems so simple, yet its lack of application seems to be the great barrier to happy and productive relationships, whether between two people or two nations. Most of the great religions and respected philosophers have acknowledged the fact.

Albert Schweitzer said: "The idea that men should ever be favored by being free from the responsibilities of self-sacrifice as men for men is foreign to the ethic of reverence for life. It requires that in some way or other and in something or other we should all live as men for men."

Albert Einstein said it this way: ". . . overemphasis on the purely intellectual attitude, often directed solely to the practical and factual, in our education, has led directly to the impairment of ethical values. I am not thinking so much of the dangers with which technical progress has directly confronted mankind, as of the stifling of mutual human consideration by a 'matter-of-fact' habit of thought which has come to lie like a killing frost upon human relations."

It is summarized in Matthew 20:39: "Love your neighbor as yourself."

DEMOCRACY was founded upon this exalted principle. Indeed, the success of a free society is contingent upon mutual responsibility; personal sacrifice for the common good. To the settlers who moved by covered wagon across this vast land, helping one another was a matter of survival. It is no less a matter of survival in 1972!

What has led us to stray from this imperative principle? Several key factors seem to have been extremely influential in shaping the attitudes of Americans over our 200 year history—especially some of the factors in more recent history. Early life in the U.S. was hard; it was a struggle; only the rugged survived. Although people came to each other's aid, one had to develop strong qualities of self-sufficiency to endure the hardships. American pioneers were a strong breed.

Individual strength, plus homage to the work ethic led our people to venerate personal independence. It was these qualities which gave us the fiber to build this prodigious society in so few years. But reverence for independence has had its negative effects. We have become too self-centered. Many have erroneously adopted the belief that, in America, anyone can make it if he wants to. While we have been devoting more and more of our energies and thought to self-indulgence, we have too often been failing to understand or recognize the plight of our fellow man. Our scientific advancement now allows the weak to survive, as well as the strong. Survive for what?

Since the turn of the century, economic factors have increased our propensities for selfishness. The great depression after World War I, which wiped out the personal and corporate estates of millions of people, left as its residue, a whole generation of Americans who have devoted undue attention to

Volunteers in Rehab

The following statement is excerpted from Dr. Edward Newman's keynote address to the Special Concern Session, White House Conference on Aging. The RSA Commissioner delivered the address on December 1, 1971.

We have broadened our horizons in rehabilitation, to accept as program goals not only a job for the disabled person, but a role in which he can express himself, fulfill his capabilities, and achieve dignity. Such a role might be volunteer work or a service role within the community.

Just a few days ago, I was presented with a progress report on a study being concluded by the Goodwill Industries on the role of volunteers in rehabilitation facilities throughout the Nation. It is a first step in our move toward a more comprehensive and effective use of volunteers in the service-delivery system of the rehabilitation program. Among other findings, the Goodwill study shows us that there is a definite parallel between intensive use of volunteers in a rehabilitation facility, and the variety and comprehensiveness of services offered by the facility. If the final report, which we expect to have next spring, provides strong indications that volunteers can be more productively used not only in serving disabled people but in upgrading the service system itself, we will look to a push toward developing the volunteer role. The secondary effect will be to provide rewarding activity for volunteers, including elderly persons whose patience, compassion, experience, and capabilities are presently being neglected.

the accumulation of money because of a basic fear of financial insecurity. Since the depression, people have accumulated more money in their lifetimes than they ever dreamed possible. A lucrative war economy has prevailed in this country for 30 years. Until August 15, 1971, inflation was accepted as a way of life. Working for "things" has become the primary purpose of life for millions of Americans. We have come to think that we can "buy" just about anything we desire.

We are either trying to ignore, or have lost sight of many of the responsibilities which life carries with it. While I have a great measure of faith in the young people of today—their idealism and their capacity for spotting and casting aside hypocrisy—I feel very sorry for many of them because they have grown up with a distorted view of the easiness of life. When they come face to face with life and the realities of its burdens, many who are unprepared, emotionally or philosophically, simply drop out, or cop out on drugs. Civilization must face squarely the irrevocable Truth that we must make sacrifices for one another if mankind is to survive. Survival requires that we spend more time being our brother's keeper and less time watching television.

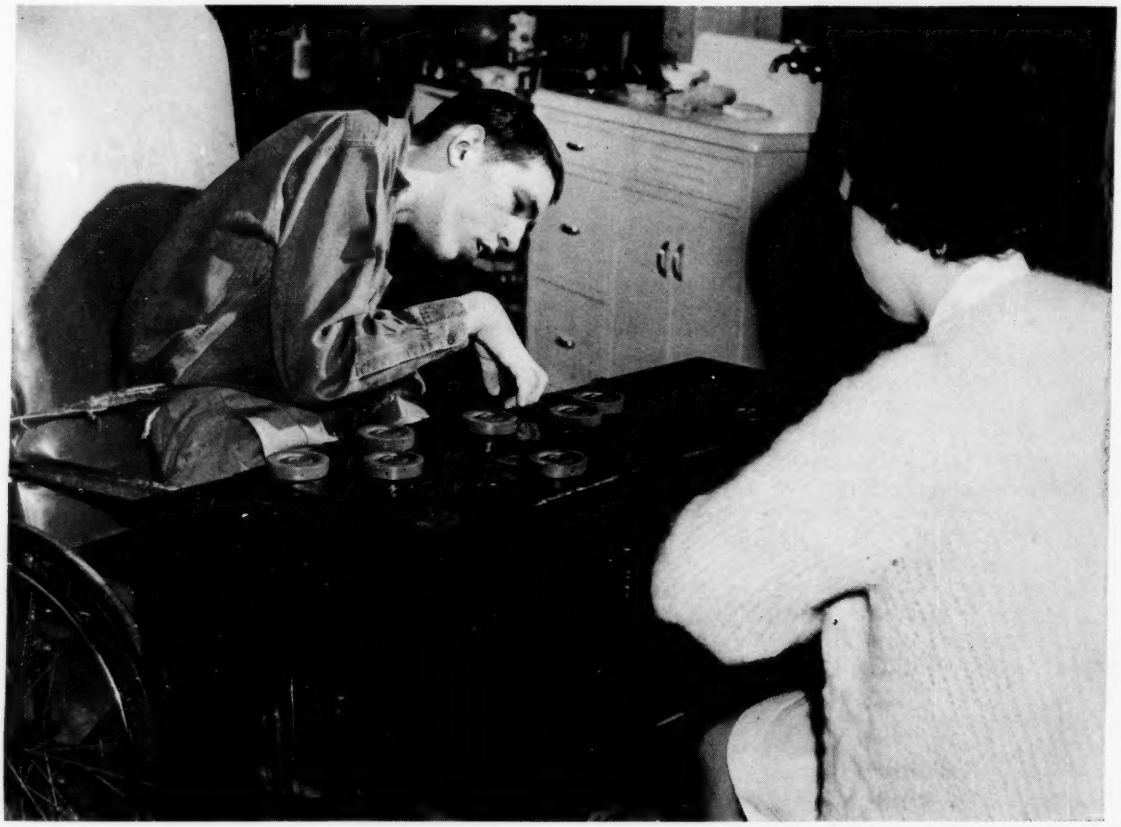
Individually, or as a nation, we cannot escape ultimate justice. We need to muster the self-discipline to take less and give more.

All of us have a craving desire for happiness. But the places we have been looking for it are not producing the desired results. Where have we been looking? Leisure, recreation, money, alcohol, and the latest place—drugs. Our revered religious prophets and the wisest minds the world has known have instructed that happiness and serenity are borne of giving. Shakespeare said: "It is one of the most beautiful compensations of this life, that no man can sincerely try to help another without helping himself." If we believe this, we have nothing to lose and everything to gain by seeking happiness in service to someone else who needs us.

IT IS RISKY to write or speak on the philosophy of volunteerism, because one almost immediately gets into the area of life purpose, religion, and philosophy—subjects about which most people have strong convictions. I do not mean to sermonize. Nor do I mean to ignore the vast amount of voluntary service which has been and is being given in this country.

I believe that the fundamentals of volunteerism are embraced by most of the accepted life philosophies. But I think we are overlooking the profound significance of it. I don't care how many think-tanks we organize; I don't care how many billions of dollars our government spends on welfare, rehabilitation programs, and all forms of domestic and foreign aid, *intellectualism and money* cannot do the job alone. People must personally help other people. It is questionable if we are serving a useful purpose when we remove a long term resident from an institution; vocationally and socially rehabilitate him; then cast him into an unknown, strange society which denies him membership. Most of our ambitious social programs will be thwarted until the spirit of mutual helpfulness permeates our way of life.

REHABILITATION is another concept which is a manifestation of some basic beliefs about



Scenes from Bethesda Lutheran Home, Watertown, Wisconsin. Recreation volunteer, above, helps Jim (a spastic) enjoy game of checkers. At left, stamps are sorted and packaged by volunteers. Proceeds are used to buy equipment for Bethesda's 660 residents.

life itself. It endorses the value and worth of every human life. It supports the belief that there is basic good in every man; that deep in every man's heart there is a desire for purpose and dignity. The rehabilitation concept says to every person: we accept you as you are and where you are; we respect you as a child of God; we want to create an arena in which you can help yourself grow and evolve.

After all, aren't these the things we all ask of life and our fellow man? Aren't we all in the process of trying to better habilitate ourselves to the world around us? In order to grow and evolve, we are dependent upon others, and others are dependent upon us. It is a basic law of the universe.

The basic purposes of volunteerism and rehabilitation are not only consonant, they are close to being identical. Doctor C. Esco Obermann, author of *A History of Vocational Rehabilitation In America,* has recently summed up the purpose of rehabilitation in three words, "facilitating one another." There is great depth and veracity in these three

words as applied to both rehabilitation and volunteerism.

The potential of volunteerism for significant impact upon rehabilitation is staggering. Presently, executive directors in rehabilitation facilities often gloss over their volunteer programs as "good for public relations," or "a nice way to get a few thousand dollars every year to help fill voids in the operating budget," or "a convenient way to handle the employee picnic." Some executive directors who have had less than satisfactory experiences with volunteers might even be inclined to describe their volunteers as "a bunch of do-gooder females I'm obliged to pacify." These attitudes serve to exemplify the underdevelopment of our skill in organizing meaningful volunteer programs. This lack of study and planning for volunteer involvement is certainly not limited to the field of rehabilitation! The whole field of volunteer administration is being given serious attention for the first time. We are just beginning to study and refine the art of successful volunteer involvement.

THE FINDINGS of a newly published research report conducted as a part of the Volunteers in Rehabilitation project* reveal that approximately 300,000 volunteers are engaged in volunteer service to rehabilitation facilities in this country. Ninety percent of them are female; 50 percent are between the ages of 35 and 64 (only 32 percent of the total population is in this age category), and approximately 40 percent have had some college experience or are college graduates (only 20 percent of the total US population falls into this category). Only 1 percent of the volunteers is handicapped, and only 1 percent is culturally and/or socially disadvantaged. These volunteers are contributing more than 1¼ million hours of service, annually, to rehabilitation facilities.

The above figures and demographic characteristics are both gratifying and disappointing. They substantiate the notable quantity of voluntary effort presently being invested in rehabilitation facilities; they reveal large segments of our society which are not extensively participating in volunteer service to rehabilitation facilities. We need to involve more blue collar workers, youth, senior citizens, handicapped persons, and disadvantaged people in voluntary service. We must make it possible for all people to be volunteers. The goal is for all humanity to engage in mutual helpfulness. Volunteerism can be described as a right . . . the right to give . . . the right to contribute.

BENEFITS of volunteering may be as great, or even greater, to the volunteer as they are to the agency and clients served. Through volunteer service, people can find useful ways in society. They can find another platform from which to express their ideas. Through personal participation, they will learn the difficulty of bringing about change in society; they will learn viable ways to initiate and implement change.

To disadvantaged citizens, volunteerism is a possible door to opportunity. There is an excellent model proving the success of this concept in the Watts section of Los Angeles. There, The South Central Volunteer Bureau, a branch of the Los Angeles Volunteer Bureau, is successfully recruiting disadvantaged, unemployed people of both sexes into volunteer service. Through experience in volunteer jobs, many gain the self-confidence and training which prepares them for eventual employment.

One might even go so far as to suggest that the inclusion of volunteers from all strata of society is a part of the total rehabilitation program of a rehab facility—in a way, we deliver service to them.

ORGANIZING for the recruitment, training, and supervision of volunteers from all educational and experiential levels will require astute planning and know-how. Efficient, meaningful volunteer programs do not just "happen." The administration of a good program takes the same kind of planning and organization required for a paid-employee program. Many administrative techniques are applicable to both, but there are some special administrative skills that we must know and apply if rehabilitation facilities are to realize the full value of volunteer service and if the volunteers are to find their experience fulfilling.

Capable volunteer service does not come "free." It requires an expenditure of time and some money. For example, a director of volunteer services, or someone serving in this capacity—whether part time or full time—is a necessity.

While more literature is beginning to be published on volunteerism, there is a paucity of material avail-

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**Sponsored by Goodwill Industries of America and the National Auxiliary to Goodwill Industries, and funded by SRS Research and Demonstration Grant No. 12–P–55087/3–02. Copies of the research report, The State of the Art of Volunteering in Rehabilitation Facilities, are available from "Volunteers in Rehabilitation," 9200 Wisconsin Avenue, Washington, D.C. 20014.*

able on the subject of volunteering in rehabilitation facilities. In May 1972, the Volunteers in Rehabilitation project will publish a set of handbooks on the subject. A complimentary set will be distributed to every rehabilitation facility in the U.S. These handbooks will be concise, practical guides on the philosophy, organization, and implementation of volunteer programs in rehabilitation facilities.

While it is clear that productive volunteer programs require effort, the payoff will prove the investment worthy . . . to the rehabilitation facility, to the client-employees it serves, to the staff, to the volunteers, to the community, and to society.

BESIDES altruistic considerations, there are the pragmatic ones. Volunteers can make it possible to deliver professional rehabilitation services and special supplementary services which rehabilitation facilities could not otherwise afford. Even if we had the money, there are not sufficient trained professionals to take the jobs. We need to mobilize unemployed professional people for part-time volunteer service. There are some things volunteers can accomplish which money cannot buy. For example, HEW has been placing emphasis on the importance of the "integrated delivery of services," which means the involvement of not only classical agencies in the rehabilitation process, but also the community itself, and its citizens. Volunteers are one of the best answers to bridging the gap.

When one lets his imagination go, and brainstorms on the possibilities for useful volunteer involvement in rehabilitation, the mind reels with ideas. Consider the contributions which *handicapped volunteers* could be making to rehabilitation programs and clients. Advisory committees of handicapped people to rehabilitation facilities could help us plan more effective programing; they could help the public understand the capabilities of handicapped people; with proper training and supervision, they could do excellent counseling; they could advise the agency and clients on prosthetics; they could lend special knowledge to training courses such as drivers' education; they could help clients make the transition to the community. These are examples of cooperation between volunteers and professionals which will result in expanded services to clients.

ARE THE AMERICAN PEOPLE ready and willing to volunteer? The Gallup Poll reveals that they are. My opinion is *yes,* with some qualifications. We must use volunteers' talents wisely, fitting the right job to the right person. Too often we have soured good volunteers by using registered nurses or women with Masters degrees in psychology to stuff envelopes or lick stamps.

People who have not heretofore volunteered need education as to the opportunities available to them and to society's need for their service. To volunteer is a free choice. But we must generate the feeling of moral responsibility to do so. While some will be easily motivated, others will not.

Volunteerism implies not only the existence of brotherly love, it requires action. It is easy to endorse the concept; it is often another story when people finally get down to weighing their own personal priorities. It is easy to rationalize about selfish interests. We console ourselves with the thought that, after all, there is love in our hearts, that we are good people trying to lead good lives, and that time simply does not allow for deeper involvement and commitment to those beyond our immediate family, friends, and business associates.

A saying on a church billboard I saw recently aptly stated it: "Don't confuse goodness with doing nothing!" But overriding this human frailty is the basic desire of people to help others, and the basic need to be needed. These basic desires and needs are not unique to middle-upperclass women of relatively high academic background who are the mainstream of volunteers today. They are characteristic of every human soul. If we make volunteer jobs available in which Americans feel they can really do something to help reverse some of the ills which plague our society, I have the faith that they will respond.

Like everything else in the world, successful voluntary involvement takes work and planning. But the dividends will be great. Volunteerism can be one of the most positive influences rehabilitation has ever experienced. ■

Paraplegics Live Longer

Of the 400 paraplegics in France in 1917–18, one-half died there and 80 percent of those who returned to the States died during the first year after their return. By way of contrast, during World War II there were 5,500 paraplegics. Thanks to antibiotics and advances in surgery—and above all to rehabilitation—80 percent of these men were alive and active 10 years later.

—Henry H. Kessler, M.D.

HOME TEACHING OF THE ADULT BLIND

HERMAN ALLWEIN

A story is told of a newly blinded woman who was annoyed because she could no longer see to do her mending. Several people offered suggestions. One thought she should apply for a larger welfare grant so she could pay someone to help her. Another, who had studied some psychiatry, told her she must become adjusted to playing a more dependent role. A third person, who just happened to be a home teacher, helped her learn to use a needle threader and do her own mending. Obviously, this story was invented by a home teacher.

Home teaching of the adult blind as a distinct form of employment began long ago when blind people were widely scattered and profoundly isolated. The printed word was far more important than it is today, and it was felt that blind people should be taught in their own homes to read and write braille and do other useful work to keep them out of the clutches of Satan. Some people still believe that blind people are a particularly high risk group when it comes to spiritual fire insurance.

Mr. Allwein, a blind rehabilitation teacher, is employed by the Pittsburgh Branch, Pennsylvania Association for the Blind. *The paper was presented at the convention of the Associated Blind of Massachusetts, October 2, 1971, in Chicopee, Massachusetts.*

The right to fail and look foolish is a right too often denied blind people

Blind people were thought to be especially suited as teachers because they could set a good example for their students and because the small salaries paid did not attract anyone else. Some people considered it a vocation akin to the priesthood into which those with limitless amounts of unselfishness poured their lives. The low salaries tended to keep out people who placed a high value on their services. The kind of uncomplaining people who accepted this situation were partly responsible for the slow improvement in working conditions. The world seldom values us more highly than we value ourselves.

Today much more is expected of the home teacher. Nobody entering the field can go far without a college education. The course given at Western Michigan University leads to a Master's degree and emphasizes work in home economics, special education, and supervised field work teaching blind adults. Home teachers' organizations are more vocal in pointing out the value of their work, though there are probably fewer than 1,000 of us in the country.

The home teacher of today quite literally gives instruction in how to be blind. Braille, typing, and handicrafts are no longer enough. The housewife must continue caring for her family. The man of the house must develop new ways to manage finances and maintain his home and family responsibilities. Even retired people have obligations in the community and to themselves to maintain a life worth living.

Things that are almost second nature to us are part of the strange world to the newly blinded person who has probably never dreamed of a life without sight. It is hard for him to realize that he may have to allow more time for some tasks. He will have to organize his whole life in a different way and do a certain amount of preventive work to keep things running smoothly. Many jobs need closer physical contact and establishment of reference points and safety patterns.

The newly blinded person must use his other senses to develop a system of identifying his possessions and communicating with himself so he can find and store the information he needs. This may involve using new tools and techniques to learn about the resources that can be especially helpful to him. He must learn to use the help he needs gracefully and efficiently while preserving his own independence and dignity.

All this will bring about changes in his thinking. He must realize he can still be an individual with a right to his own feelings, responsible for his own behavior, and must decide for himself what is important. The way he feels about his own adjustment is often more important than the situation itself. Only in doing things for himself can he develop new solutions to his problems, not by manipulating those around him. The one ability we all have is the ability to change. He must be sensitive enough to be hurt and tough enough to heal.

As I reread the last few paragraphs, I am impressed by the fact that over and over again I find the words, "he must learn." This is the kind of thing teachers are always saying. We are impressed by the idea that what needs to be learned can be taught. Though we can outline a course in learning to use the abacus, it is almost impossible to draw up one to improve the way we feel about other people.

In this age of big words and professionalism, home teachers have become rehabilitation teachers. This is not just a matter of replacing one word with a bigger one. The frontiers of rehabilitation teaching reach into mental hospitals and nursing homes. Ad-

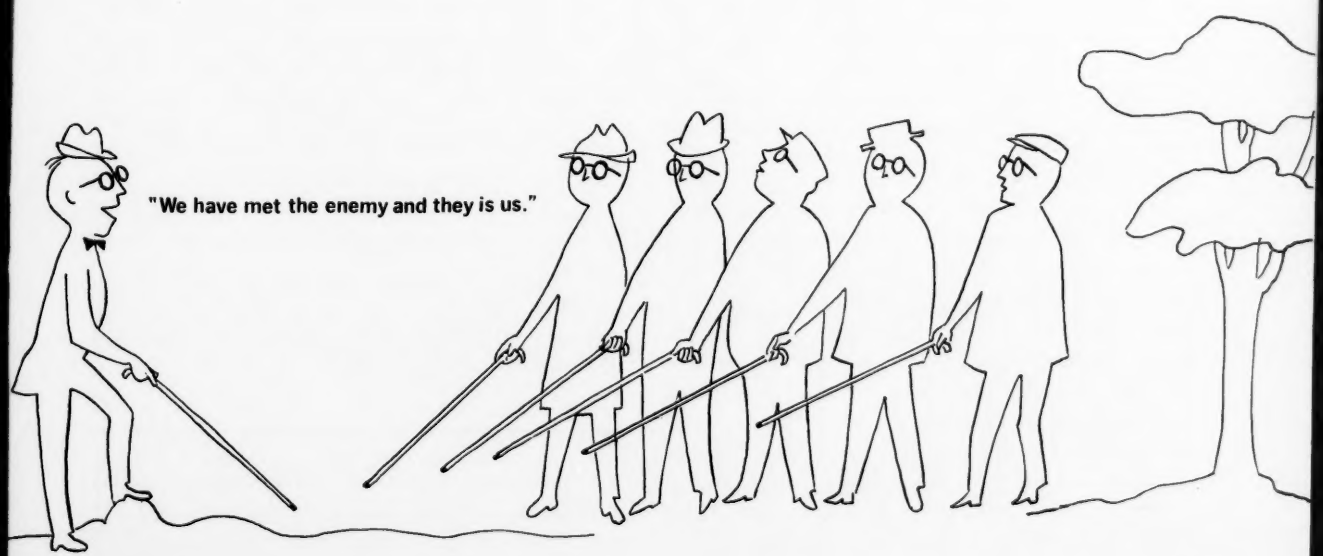
justment training centers and other facilities provide the same kind of training available from the home teacher. Some home teachers now work in these centers along with other people of widely different backgrounds. They all do similar work, although they seldom work on a common ground of respect and cooperation. No longer are sighted people virtually excluded from the field. Ability counts for more than disability. Blindness alone does not give me more insight than a trained, experienced, understanding sighted person.

Many people ask whether the old fashioned home teacher who has threaded his way up and down the land has outlived his usefulness. Could not his work be done more effectively at a center with a staff and equipment that can be concentrated to help several students at once? Many people do receive better, more systematic training, more quickly and perhaps more economically in this way, but others, for one reason or another, do not take full advantage of such centers, or they may need the home teacher as a stepping stone to such a center, or need more help after they have left. Because of geography, personal circumstances or agency policy they may never reach such a center. The home teacher offers an alternative.

Not everyone fits neatly into the pigeonholes an all-wise society has prepared for us. Big brother often knows what we need better than we do ourselves, but even big brothers can be wrong. Just because blind people do not wish to follow the clearly marked tracks laid down before them, they cannot automatically be labeled as maladjusted. How monotonous the sounds of the forest would be if the music came only from the top 10 birds! Services must be geared to help as many blind people as possible.

According to statistics the average legally blind person is over 65 years old and is more likely than the average to have some other handicap. He may well have less than the average amount of schooling and income and may be less aware of what blind people can do. It may be harder for him to change his thinking, and his attitude is less likely to be what we call progressive and forward looking. Having been raised in a different world, he may be satisfied with a life more restricted than it needs to be. What seems good enough for him falls far short of our own ideas. In the long commercial of life he often feels like brand x. It is easy to paint pictures of the average blind man, but much harder to find him. Actually the average blind man is probably a woman.

In these days of computers and trips to the moon, being able to type a letter without sight, or balance your own checkbook, or cook a meal that tastes



as good as ever will never put your picture on the cover of *Life* magazine. Victories over self pity and despair, two of the most potent drugs available without a prescription, will not set the world on fire but will help to make it a warmer, more comfortable place to live in, despite an alcoholic brother-in-law, a nagging wife, an arthritic shoulder, an inadequate income, and a failing memory. People are like rockets, and we must accept the fact that there are few times in their lives when systems are all go.

Failure does not have to be a tragedy. There is no comparison between what is lost by not succeeding and what is lost by not trying. Failure is sometimes just a detour to success. The right to fail and look foolish is a right too often denied blind people. What disaster will befall a student who never becomes a famous virtuoso on the krummhorn? What if he saves his money for a trip he has always dreamed about, while ignoring things that seem to us more important? Must he always play it safe and be protected against all possible failures, and successes? Although the world has not yet developed a cure for the common person, it becomes more obvious everyday that the best thing we can do is be ourselves. Everyone can make a difference and everyone must try. None of us were made to breathe oxygen, to talk poetry or to be always wise.

What kind of people should become home teachers? If you need a continuous diet of brilliant successes, you had better look for another job. Sometimes you cannot even distinguish success from failure. What looks like success can be swept away in the few seconds it takes for a heart attack to do its work. All the hard work that goes into a project that fails is less likely to be recognized than a success that comes by chance. The world is not much interested in labor pains; it just wants to see the baby.

As we see some of our students slide downhill, we must ask whether we ourselves have cared enough, tried enough, understood enough, sacrificed enough long enough. The answers to these questions cannot be found in the back of the book. As that great philosopher of the comic pages, Pogo, has told us, "We have met the enemy and they is us." We ain't what we ought to be; we ain't what we want to be; we ain't what we used to be; and we ain't what we are going to be. Human beings are not perfectible, only improvable. It is up to us whether we spell life *sacred* or *scared*.

AGING PREVENTION

The following quote is taken from a paper entitled "Aging—At Any Age" by Frederick C. Swartz, M.D. It was presented at the Tennessee State White House Conference on Aging held in Nashville, May 11–12, 1971. The paper appeared in the *Tennessee Public Welfare Record* and the quote is reprinted here with permission of the editor.

Aside from problems resulting from retirement, the aging have no health problems that are not also problems for every other age group. On the other hand, lack of conditioning accounts for many of the so-called infirmities of age. What can we do about this? We can take advantage of what is now known about the importance of:

1. Periodic physical examinations. The advantages are obvious, especially since early diagnosis can often prevent crisis treatment.
2. Daily physical exercise. The tottering gait and shaking hand are the result of lack of physical conditioning. If a person has them, it is his own fault. The painful knees and flat feet that result from the pounding of too much weight represent long-time lack of care and not the passage of years.
3. Mental exercise. If your mind doesn't work, you are not getting old; you are getting lazy. It is necessary to keep the habit of concentrating. You should concentrate at least 15 to 30 minutes every day on a subject that makes you look things up, talk to somebody about it, or otherwise search for information. Forgetfulness comes when the mind is not used.
4. Good nutrition. Although some older people have poor nutrition because of lack of income or education, 28 to 30 percent of the American population, including older persons, are definitely overweight. Overweight, in itself, presents a serious health problem.
5. Preventive medicine. Take full advantage of vaccinations, inoculations, and other developments in medical care which can prevent illness and disability.
6. Moderate habits. Alcohol is poison with calories; cigarettes are pure poison; both are associated with morbidity in 15 of the major causes of death.

■

"The road to wisdom? Well it is simple to express: to fail, and fail and fail again, but less, and less, and less." *Grooks* by Piet Hein. ■

The State of Blindness; Its Counselors of State; And Its Citizens

WARREN BLEDSOE

The field of works for the blind is not, as some people suppose, narrow. The ubiquitousness of the intrusion of blindness into every area of performance of blind people with a variety of temperaments has required multiple solutions to a variety of problems involving all sorts of sciences, knowledge, and skills.

In the same day anyone in charge of a program for blind people might well wish he were an engineer, a lawyer, a social worker, a psychologist, an optometrist, an accountant, a statistician, and possibly a detective and a newspaper editor. Problems which seem to require expertise in all these areas are not uncommon. First, last, and always the talents of a diplomat are required to enlist and draw upon the above-named and many more competencies which the situations of blind people bring into play in the modern world.

So a historian of work for the blind might well be expected to trace the development of medical care of the eye, the development of finger reading, the development of sound-recording, laws affecting the blind, industry and the blind, the professions and the blind, mechanical aids, eyeglasses for the low-visioned, and various other subjects significant in the lives of blind people. Needless to say this is not an easy task.

Though blindness is commonly regarded as a physical handicap, up to now the social means to overcome it have far exceeded the mechanical means. In my opinion the key factor in meeting the challenge of the future in work for the blind will continue to be people playing certain roles. Elsewhere I have several times described what I conceive these roles to be: (1) the status figures or cynosures, (2) the hewers and haulers, fetchers and carriers, (3) the inventors, (4) the shining examples, (5) the stormy petrels or agitators.

A few months ago I began to notice another role which is separate and distinct from the others. This role, in my opinion, is that of the counselor of state: any State of the United States or the whole United States, Lichtenstein, Yugoslavia, Spain. And, I have experimented with writing down what I think is required of such a counselor. It is as follows:

- Ease with blind and sighted people.
- Real true familiarity with the things blind people can and cannot do.
- Diplomacy in managing the embarrassing dictum "blind people can do anything."
- Total absence of snobbishness toward the practitioner "down in the mud" with blind people.
- Ability to conjure with the national passion for the mechanical solution to blindness. (Also the reverence for statistics and bigness.)

Mr. Bledsoe is consultant to the Office For Blind and Visually Handicapped, RSA. These are remarks excerpted from a longer paper delivered as the keynote address to the Mid-Atlantic Regional Conference of the American Association of Workers for the Blind. The original paper was titled Gearing To Meet The Challenge of the Decade. The conference was held in New York City on September 23, 1970.

• Ability to master the barricade "You will never know what it is to be blind"—either by blindness itself or an intuitive quality which is an adequate substitute.

• Willingness to keep up with a considerable number of areas, subjects, technicalities with which impaired eyesight involves the human being. (This is where the *narrow* subject of blindness becomes very *broad.*) (Finger reading, optics, statistics, small business, sociology, et al.)

• Whereas all other counselors of state have many other worthy commitments, this counselor should have a judicious, but highly serious commitment to blind people in all *quid pro quos.* (The able, ambitious fellow on his way somewhere has a disappointing tendency to sell out when the chips are down. However, there are exceptions when men on their way make fine contributions and manage their interests without conflict.)

• Ability to belong to the state of which he is counselor, and to blind people, not to agile folk who are champions at getting to such people as he.

• Imagination and openmindedness coupled with an uncanny ability to spot quacks, frauds, and insane people.

• A strong tendency to feel joy when other people flourish, to regard crisis and obstacles as worthy enemies, but outcomes, resolutions, and smooth motion as beloved friends.

• Ability to keep his head when all about him are losing theirs and blaming it on him.

• He (or she) must fear no evil.

• Whatever his education is, it should have given him some idea of what a state is, and how it has evolved.

• Whatever his upbringing, it should have given him some idea of what a human being is, and how *it* has evolved.

Whatever has been going on in other phases of the national life, work for the blind has been in a period of expanded investment during the past 3 decades. The Social and Rehabilitation Services alone has put $10 million into research and demonstration since 1954 when the Vocational Rehabilitation Act was revised to include funds for such a program.

The administrator and the chiefs of services to the blind and visually handicapped have had an understanding which has been based on recognition of the importance of the people at the grass roots: the fetchers and carriers, hewers and haulers in direct contact with blind people, who actually play the leading roles in work for the blind.

It is said that there are only two real ranks in the Catholic church: Bishop and priest. Perhaps work for the blind might reduce itself to two: those counselors of state of whom we spoke and direct contact people. I have given my job description of the counselor of state. I would like to do the same for the direct contact people, a credo occasioned by some rather cynical remarks once made in my presence.

Credo Ascribed To Certain Masters Of The Art Of Teaching Blind People

I hold the art of teaching blind people how to perform without sight among the highest callings which a human being may answer with his life. If at any time through my own infirmity, or to fill a power vacuum, the day comes when I must become a mere executive, supervisor or administrator, I will remember that, no matter how it seems to the worldly, the true apex of work for the blind is personal service in direct contact with blind people, and that all organized work for the blind has no other end but this, as well-performed as available knowledge permits.

During the years when it is my privilege to practice the art, I will do my uttermost, not only to extend my own effectiveness, and the effectiveness of others, but also to devise ways of imparting efficiency with all the tact and kindness of which I am capable, bearing in mind that the most cherished attribute a person has is his self-esteem, based on a sense of worth, the quintessence of which is independence.

I will keep in mind that a severe handicap, particularly in its early stages, or if it goes for a long time untended, requires that an individual be a constant recipient of so much help that the burden recurrently seems intolerable, and that my actions and attitudes should never increase this burden by any kind of ostentation in my bearing toward my work or blind people. Without morbid self-effacement or subservience, I will avoid any form of encroachment upon the individuality of those I serve, especially subtle usurping of credit for their performance.

I will keep my emotions in such order that I will not seek exceptional satisfaction from relationships with those I help, and will steadily perform in such a way as to encourage them to rely on and be preoccupied with those persons it is most natural and desirable for them to know and to love.

To my working hours I will give the most complete attention of the most creative kind of which I am capable, dwelling constantly on every practicality which can render a human being without sight a person of value in his own eyes.

I will guard my tongue and my time, but give generously my knowledge and experience to others who are also devoted to this art which is my calling.

I will reserve my scorn for those who aspire to be my colleagues without true respect for the calling, who are cynical toward all these things in which I believe, and without diligence and care in performing their duties. These I will relentlessly harry out of the field by open and aboveboard strictures and sanctions without any regard for influence which such persons may muster to counterattack.

I will not spoil blind people, or encourage them to become mere charming enslavers of those around them. I will look to the long view in helping them, not to ease of the moment. But I will stop short of making myself a compulsive taskmaster over the people whom I serve.

No matter how my battles go, once a conflict is resolved, I will put it behind me and rest and recondition my heart, mind and body for further action in the long, creative endeavor which will govern all the days of my life.

I have been asked if I have ever known such people. I have indeed—many of them—from the kindergarten teacher at the Maryland School for the Blind in the 1920's to people here in this room. ■

THE PEOPLE, YES

The following material is quoted from *Hospital & Community Psychiatry,* January 1972. The first two paragraphs are excerpted from the article, "Future Changes in Mental Health Care," by Thomas N. Rusk, M.D.; and the last is from a letter by Thomas D. Sevy, A.C.S.W.

. . . The American public increasingly abhors the view that medicine in general and mental health practice in particular should be offered as an elective service by physicians operating as small businessmen. Such services are coming to be viewed as the fundamental birthright of every American, to be provided by a highly skilled health team. The physician's naiveté about administration and delivery of efficient services is no longer being condoned, nor is the corresponding naiveté of most lay health administrators about the intricacies of medical and psychiatric practice tolerable.

The day of the subordinate, supplicating, passive, ignorant patient is gone. He is knowledgeable and demanding. He wants his caregivers to be local people who look, talk, and act like him, even speak and write in a way that he can understand. In mental health we can ride this tide to deliver more effective care than we ever imagined. We can be partners rather than caregivers, consultants rather than healers, promoters of learning and growth rather than infantilizing nurturers. We can be community interventionists helping to guide consumer power rather than hypocritical, self-deceiving wardens, gatekeepers, and guards of society's banishment system.

* * * * *

Social Darwinism, or survival of the fittest, has no place in the treatment of the mentally ill. A challenge that all personnel at all levels might well accept is to examine current programs and therapeutic efforts, to determine the philosophy adopted toward patients who do not respond to treatment. We have the responsibility to make our services more consumer-oriented, not to take the stance that we have a service that only those who are sufficiently motivated can take advantage of.

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IN THE HEALTH AND WELFARE FIELD

The Good And The Bad

JOHN H. NOBLE, JR., PH.D.

Discussion of the utility and potential dangers of automating information first needs to be based on an understanding of how computers work. Basically, they are machines which follow sets of instructions called "programs" to read information, process it, and display results. "Digital" computers use and display information in the form of numbers and alphabetic characters, while "analog" computers represent information like slide rules, as physical quantities. Whereas analog computers are used primarily by physical scientists, social scientists and agency personnel most often use digital computers.

COMPUTER ANATOMY

Digital computers typically consist of four components: one or more input-output devices, one or more storage devices, an arithmetic and logical unit, and a control unit. Input-output devices serve to read information into the computer and to display the results of processing. They include, for example, electric typewriters, punched card readers and punches, magnetic tape units, and cathode ray tube display consoles.

Digital computers store information in the form of a series of electric charges, called "binary" codes (represented by 0 or 1), in both internal and external locations. Millions of bits or positions of internal storage permit access to information in millionths of a second (microseconds). External storage devices provide additional space for several billion more bits of information at slower access speeds, measured in thousandths of a second (milliseconds). These storage devices employ a variety of magnetic media to record information, such as tapes, drums, disks, cards, and strips. A recently developed high-capacity computer storage system makes it possible to maintain a dossier on every living person in the U.S. and to retrieve any one of them in 28 seconds.[1]

The arithmetic and logical unit contains electronic components and circuitry permitting it to perform operations at speeds measured in billionths of a second (nanoseconds). Finally, a control unit follows and executes sequentially stored programs of instructions to guide processing of information read into the computer to achieve the results to be displayed on one or more of the output devices.

COMPUTER PHYSIOLOGY

Computers operate either in periodic, batch mode or in continuous, on-line mode. In periodic, batch mode processing, files of information (together with the programs governing processing and display) are submitted periodically as "jobs." Each job is stacked with other jobs and is read, in turn, into the computer, processed, and the results typically obtained in printed form.

In continuous, on-line processing, files of information are fed more or less continuously into the computer and kept up-to-date from input devices often located some distance from the computer. These input devices, called "on-line" terminals or consoles, usually consist of teletypewriters, punched

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card readers and cathode ray tubes, activated, for example, by a pen flashlight. The programed results of processing may be displayed upon command or according to schedule at one or more on-line terminals in printed, punched-card, or visual form.

Airline passenger scheduling is perhaps the one continuous, on-line computer processing system most familiar to us. This system also shows how continuous computer processing can serve as a communications network, linking widely separated persons and organizations by means of pooled information.

This background underlines the computer's neutrality. Responsibility for pursuit of beneficial or destructive goals belongs to the men and organizations who exploit its high-speed capacity for storage, retrieval, and analysis.

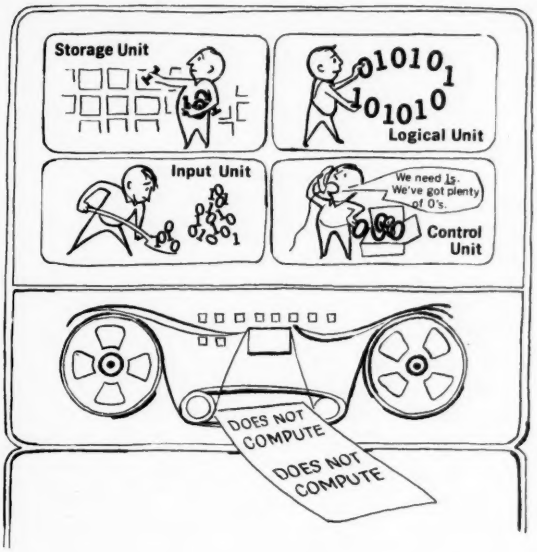
COMPUTERS FOR ADMINISTRATOR OR CLINICIAN?

Pulier [2] observes that "there will always be two contradictory trends," one toward larger, centralized, and administratively-oriented systems and the other toward smaller, clinically-oriented and probably less standardized uses of the computer.

IMPAC Systems, Inc., for example, places emphasis upon the design of information systems which support the types of recurring decisions that administrators of complex organizations must make. McCurdy [3] enumerates these major decisions, and they include: assessing community needs, determining the cost of potential services, planning programs, preparing for staff development, establishing fee scales, and designing appropriate organizational structures.

In a similar vein, Fuller [4] shows how *ad hoc* use of the computer to perform the complex calculations of Monte Carlo simulation can help the administrator to justify assignment of an additional staff position to an alcoholic clinic. He also demonstrates the utility of the computer in merging and analyzing large masses of data derived from several sources to pinpoint high risk populations and geographic areas as the basis for program planning.

At the other end of the continuum, Pulier [5] and Silver [6] both stress clinical applications designed to emphasize and support the client-professional unit, upon which health and social welfare agencies providing clinical services ultimately rely to achieve their therapeutic goals. Although admittedly costly because of the small scale and variable character of the decision-making process at the clinical level,



the approach is offered as a "check and balance" against high-level administrative decisions which may be unresponsive to the needs of the total number of client-professional units comprising the clinical setting.

Thus, Silver seeks to use the computer to assist social workers on the psychiatric inpatient service at Walter Reed General Hospital to reduce the time spent by patient and worker on important yet therapeutically insignificant details. Automation of some aspects of the social service inventory, routinely administered as part of the admission process, appears to be a wise choice because a number of elements in the desired functional performance of a social worker on a psychiatric inpatient service can be thereby explicitly and simultaneously linked.

As Silver has indicated, these functional elements include: gathering systematic historical data, dispensing answers to routine questions that patients have regarding hospitalization, providing a format or opportunity for patients to make known specific problems and difficulties, promoting action by service delivery personnel, and keeping track of interventive actions taken by staff.

One might ask: "What are the chances that resources will be invested in computer applications which support the clinician rather than the administrator?" The answer depends upon a number of variables, including the service delivery sector addressed—public or private, charity-supported or profit-making, the nature of services offered, and the

degree of experience or sophistication of the decision-maker about computers. Until computers and/or computer time become cheap, everyday commodities, the odds are tipped in favor of administrative applications of the computer. Administrators hold the purse and must assume responsibility for allocating scarce resources among competing demands; they must also monitor and control performance at every level of the organization. It is natural for them first to meet their own need for information.

COMPUTERS IN THE PUBLIC SECTOR

Monitoring and control of expenditures become the transcendent issue when public funds are in question, and administrative needs are reinforced thereby. The advent of Medicaid has given impetus to the development of a number of computerized information systems, such as hospital utilization review and the National Data Processing (NDP) demonstration project. The first seeks to establish and maintain empirically-derived norms governing length of hospital stay for specific diseases and surgical procedures. The latter, among other things, monitors the amount of Medicaid funds individual physicians receive from practice. If the Family Assistance Plan becomes law, the administering department will undoubtedly set up a nationwide information system similar to that of the Social Security Administration to monitor the eligibility determination process and to keep track of benefits paid to recipients.

The private sector will be subject to the reporting requirements of public agencies to the extent that they become involved through contract to provide services to beneficiaries of the public programs. What is more, because of the considerable costs associated with development and maintenance of computerized information systems, it is unlikely that private agencies will be able to afford systems which simultaneously cater to the demands for information from the public programs and their own ideosyncratic need—unless the public sector subsidizes them.

COMPUTERS IN THE PRIVATE SECTOR

Profit-making purveyors of clinical services and clinicians within well-endowed public and private institutions appear to be the favored few who, in the near term, will be able to indulge themselves in clinical applications of the computer.

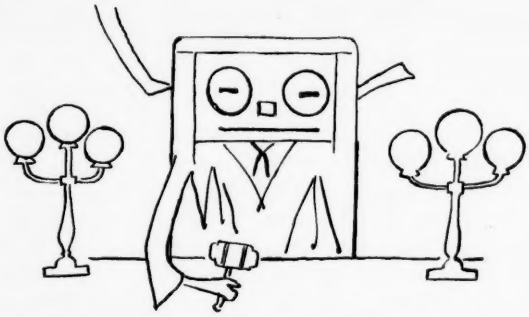
In June 1971, private physicians and other users of medical data in the Midwest willing to pay $450 per month became eligible to purchase from Medical Data Systems, Inc., computerized recordkeeping services.[7] By pressing the few keys on a CRT terminal necessary to register the patient's name or Social Security number and his own code number, the physican can obtain a detailed medical record for inspection or updating. In addition, the system provides automatic accounting and billing services, including completion of standard medical insurance forms used by Medicare, Blue Cross, Blue Shield, etc. Obviously, such a system offers substantial opportunities for information exchange among physicians, hospitals, and nursing homes and for epidemiologic and clinical research.

QUESTIONS FOR CONSIDERATION

In taking advantage of the new technology, administrators and clinicians will want to keep a few caveats in mind. Automation increases rather than diminishes the need to consider the range of functional, methodological, legal, political, and economic issues that confront any knowledge-seeking enterprise. These issues include:

- Which attributes of people, organizations, and communities shall be measured for what purposes?
- Can these attributes be measured so that they are sufficiently reliable and valid to attain specified objectives?
- If some people and some organizations cannot or will not share needed information about themselves, how many must cooperate to permit valid inference and adequate control for bias?
- Faced with competition for scarce resources of money, technical manpower, and computers, should decision makers accept a system designed to collect information on whole universes of people, organizations, and geographic areas? Or can sampling and periodic surveys achieve the same results more efficiently?
- For any set of data, what are the relative costs associated with alternative means of collecting, processing, and promulgating findings?
- Does there exist a sufficient number of potential users to justify the cost of developing and maintaining a system? Will these potential users support a system financially and politically? [8]

Raising these questions is not nit-picking. Most of the major problems facing the computer industry



"One commentator, tongue-in-cheek, predicted development within 10 years of a new 'growth industry' relating to computers—lawsuits against computer companies."

and its customers today stem from "hard-sell" marketing techniques which have attempted to bypass serious effort to obtain particularized answers to them. For example, the consensus of speakers at the 24th Annual International Systems Meeting of the Association for Systems Management was that "the time has arrived for the data processing professional to 'clean up his own act,' to start remembering that he is a part of the corporation paying him, to be certain that his systems are providing information, and not just an electronic form of creative expression for his own people alone, and to begin to understand effectively both the man and the job of the man to whom he provides information." [9]

One commentator, tongue-in-cheek, predicted development within 10 years of a new "growth industry" relating to computers—lawsuits against computer companies. In his opinion, the body of existing law concerned with negligence, breach of contract, breach of warranty, product liability, fraud, misrepresentation, and invasion of privacy is sufficient to cover the violations of standards and levels of performance that have occurred in the computer industry.[10]

Finally, health and social work professionals have a large stake in the outcome of the hearings now being held before the Senate Constitutional Rights Subcommittee, concerning "Computers, Data Banks, and the Bill of Rights." Although most people would agree that collection of vast amounts of information about individuals in computerized data banks presents a potential threat to personal privacy and freedom, it is not clear what kinds of safeguards will suffice to strike a balance between the individual's right to privacy and society's right to information needed for preservation of the "common good." On this issue, the public interest and the special interests of professionals are joined. To satisfy the health and social welfare field, any computerized information system will have to give clear indication how both the client's right to restrict information about himself (privacy) and the professional's obligation to do so (confidentiality) are protected.[11]

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HEART ATTACK PREDICTION SOUGHT

A New York University Medical Center research project has received a grant from the John A. Hartford Foundation to find a method of predicting the actual time when a person will suffer a heart attack or a stroke.

Principal investigator for the project is Dr. Menard M. Gertler, professor of experimental rehabilitation medicine at the Center. He and his associates have previously established under an SRS-supported grant the predictability of ischemic heart disease (narrowing or blockage of coronary arteries) and ischemic thrombotic cerebrovascular disease (blockage of arteries in the brain due to blood clotting and narrowing of the vessels, causing stroke). But being able to say that a person "will suffer a heart attack or a stroke" is not sufficient; answering the question "when" is the crucial indicator that would allow, when answered, the physician to intervene with the proper therapy.

To answer this question of "when," the researchers will study the changes in blood liquidity and its tendency toward coagulation. In general and in specific areas of the body, blood liquidity changes gradually, and it is the recognition of the changing state that must be determined early in order to know when to intervene with anti-coagulant drugs.

Drug Misuse. Charles Scribner's Sons, 597 Fifth Ave., New York, N.Y. 10017. 93 pages. $4.95 cloth. $1.95 paperback.

Subtitled "A Psychiatric View of a Modern Dilemma," the book is the product of the Committee on Mental Health Services, Group for the Advancement of Psychiatry. It reviews drug misuse in our society and looks at the factors contributing to the problem and what is and is not known about various drugs. The medical-legal considerations about and surrounding drugs are also reviewed.

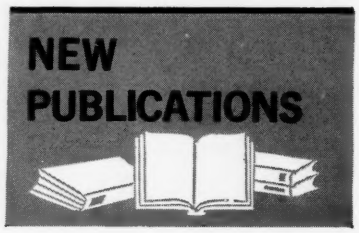
A short statement, under the title "If Marijuana Were Legalized," examines some of the effects that might transpire if legalization were implemented and the controls that would be necessary through taxation, dealer licensing, etc. A final short statement presents recommendations which include advocating more research into drug effect, causes of misuse, and treatment, and a re-examination by physicians of their use of mood- and behavior-altering drugs.

Workshops for the Handicapped in the United States. Nathan Nelson, Ph. D. Charles C. Thomas, 301–327 East Lawrence Ave., Springfield, Ill. 62703. 466 pages. $16.

True to its subtitle, "An Historical and Developmental Perspective," the book looks at the past, present, and future of the workshop movement in the U.S. The author is an associate professor for rehabilitation services at DePaul University, and he was formerly chief rehabilitation workshop consultant for the California Department of Rehabilitation.

In his discussion of present-day workshops, the author surveys such questions as workshop nature, objectives, philosophies, theories, and practices. He also reviews workshop organization, administration, financing, and the development of standards and accreditation. An appendix provides a summary of standards for the operation of workshops which is based on the statements of standard-setting organizations, such as Goodwill Industries of America and the Commission on Accreditation of Rehabilitation Facilities.

The facilities are presented by characteristic, such as comprehensive facilities (both urban and regional), those with special disability or program emphasis, those related to a hospital, and the rehabilitation hospital itself.



How To Beat The Establishment and Get That JOB! Norman File and Bernard Howroyd. Apple/One Publishing Co., 3923 West 6th St., Suite 416, Los Angeles, Calif. 90020. 179 pages. $2.95.

Opening with a general discussion of jobs, job finding, job meaning, mental attitudes, the book moves on to discuss media and how to use it, employment agencies, the resume, the interview, and the unique consideration of "for women only" jobs. A chapter on tests and testing considers many of the types of tests administered by personnel departments. The rationale of answering many different types of questions is given.

Let's End Isolation. Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. 46 pages. 30 cents.

Many conditions and lack of services combine to isolate older people. This Administration on Aging publication briefly describes the services that can alleviate or ameliorate isolation for the older citizen. The descriptions are reinforced by concrete operational examples. Areas covered include transportation, senior centers, in-home and outreach services, and projects in telephone reassurance, visiting, placement, and information and referral.

A System For Planning And Achieving Comprehensive Health Care In Residential Institutions For The Mentally Retarded. Harold A. Decker, M.D. Medical Center, University of Arkansas Medical Center, 4301 West Markham St., Little Rock, Ark. 98 pages.

This monograph, published by the University of Michigan Press and addressed primarily to the staff of residential institutions for the mentally retarded, presents a system whereby such institutions can plan and carry through comprehensive and coordinated, individualized, health and habilitation care on a continuing, long term basis.

The author, being a physician, approaches institutional care for the retarded with a special concern for their health and for handicapping conditions that limit function. Recognizing, however, the mutual interaction of medical, intellectual, emotional and social factors in determining the degree of success the handicapped achieve, he views health care in a way that intertwines medicine intimately with other components of institutional care. Accordingly, the proposed system focuses on techniques for achieving a full range of preventive, curative and rehabilitative services; and furthermore, assumes the stance that the primary physician will contribute routinely on a cooperative, advisory and consultative basis to the design of educational, socialization, residential, and vocational programs which are directed by other professional people.

The author's views are addressed first to physicians and others in health professions who serve institutionalized populations. Other staff members of institutions will be interested in these comments, however, because of the health implications of their own activities and

because of the contributions that physicians and other health personnel can make to their own services.

Though developed specifically for use with institutionalized mentally retarded populations, the principles of this system and most of its operating procedures could be used with little modification in institutional settings for the deaf, the blind, and mentally sound, physically handicapped persons. The principles of the system are equally applicable to the care of handicapped persons residing in noninstitutional settings, and with suitable adaptations in methodology, many aspects of the system could be used with such populations.

Sight Restoration After Long Term Blindness: The Problems and Behavior Patterns of Visual Rehabilitation. Alberto Valvo, M.D. American Foundation For The Blind, Inc., 15 West 16th St., New York, N.Y. 10011. 54 pages. $4.

The following is excerpted from "A Note From The Publisher" and written by M. Robert Barnett, Executive Director, American Foundation For The Blind.

In this volume, Alberto Valvo, M.D., describes clearly and in detail the long and arduous process of restoring visual functioning in persons who have recovered sight through an operation after long term blindness. Since the number of such cases is and will remain small, the amount of practical value this book may have for persons in work for the blind may be questioned. There are, however, many aspects of this study that the Foundation believes will be of great interest and value to persons involved in working with the blind and visually handicapped, particularly in the areas of education and rehabilitation.

One of these aspects is the material the study presents on perception—with and without vision. The subjects described are all intelligent, articulate adults who as blind persons had perceived and dealt with their environments adequately. Their own subjective reports on the task of achieving the same goal with vision as the main sensory channel and the detailed observations of the author and his associates reveal much about the difference between different systems of perception and activity. They also demonstrate that these are indeed systems—complex networks of habits, which require time, learning, and practice to develop to a useful level.

This study also presents clear evidence of the great strain and anguish which accompany a radical change in established habits of perception and behavior. It indicates the great cost to the human psyche of any radical change—a matter of interest far beyond the fields of rehabilitation and education in this rapidly changing world.

Future Directions For Home Economics In Rehabilitation. American Home Economics Association, 2010 Massachusetts Ave., N.W., Washington, D.C. 20036. 106 pages. $5.

This is the report of the proceedings of the Second Inter-displinary Workshop held at the University of Oklahoma on March 16–19, 1969. The papers review home economics programs already in action and undertake a description of the challenges to full service by 1975. The papers also cover training needs and resources.

Identifying Suicide Potential. Dorothy B. Anderson and Lenora J. McClean, editors. Behavioral Publications, 2852 Broadway, Morningside Heights, New York, N.Y. 10025. 112 pages. $7.45.

Aspects of the urgent problems of investigating and recognizing presuicidal phenomena are examined by experts bringing diverse orientations and disciplinary approaches to a shared goal of decreasing the high suicide rate. Eleven symposium papers (The symposium was held at Teachers College, Columbia University in December 1969.) focus on the extent of suicide potential and the forces affecting this tendency in society at large, the family system, and specific high-risk groups.

Editorial commentary supplies material derived from the discussion periods following the presentation of each paper, while an appendix of two documents not read at the conference provides specific information on educating the lay public in effectively working with suicidal friends and relatives.

Rehabilitation Medicine. Howard A. Rusk, M.D., Howard A. Rusk, M.D., and Eugene J. Taylor, editors. The C. V. Mosby Company, 3207 Washington Blvd., St. Louis, Mo. 63103. 687 pages. $21.

This book has been used widely as a textbook and general reference. In its present third edition the author expands and in some cases rewrites sections on cardiovascular and cerebrovascular diseases, cancer, chronic obstructive lung disease, amputee management, and externally powered orthoses and prostheses. There have been Spanish, Croatian, and Japanese editions of the book.

In conjunction with 36 collaborators, Dr. Rusk exhaustively delves into the principles in a host of areas, such as physical medicine, physical and occupational therapy, use of the wheelchair, homemaking, rehabilitation nursing, and psychiatric, social, and vocational problems, to name but a few. He also discusses the rehabilitation of patients with such diseases and conditions as para and quadriplegia, stroke, cancer, cerebral palsy, and many others.

Workshop On Continuing Education For Deaf Adults. Max Friedman and Martin Hall, editors. Deafness Research and Training Center, New York University School of Education, New York, N.Y. 59 pages.

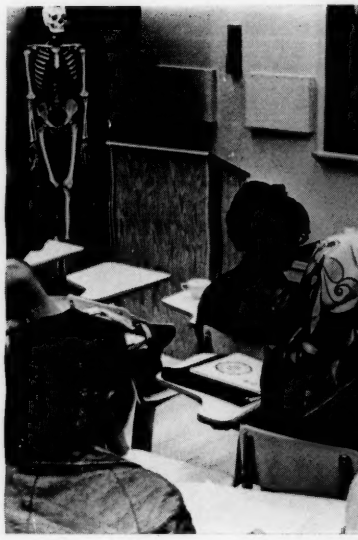
The proceedings of a workshop held in Kansas City, Missouri, on October 19–21, 1969, this book looks at general educational requirements

(Continued on page 27.)

Black Students Prepare For Rehabilitati

BRUCE M. SIEGENTHALER, PH. D.

Students observe speech therapy demonstration.



Students learn anatomy of speech mechan

There are 20 million speech, hearing, and language impaired persons living in the U.S., but the bulk of this disabled population remains untapped by the professional workers in the speech and audiology field. A large percentage of the minority group populations with these disorders also remains unserved. Professional black speech pathologists and audiologists can contribute immeasurably to the restitution of normal life to all those needing these services. This is especially so for the black disabled population. Because he already understands their needs, the black professional not only can contribute in direct services to this disabled clientele, but he can dramatize to the population at large the needs in this area and for these people.

Dr. Siegenthaler is the director of the Speech and Hearing Clinic, The Pennsylvania State University.

The field of speech pathology and audiology has a heightened interest in including members of minority groups as full participants in this profession which makes significant contributions to the rehabilitation of many vocationally handicapped persons. That participation by blacks has not yet been adequately accomplished is seen in the membership statistics of the American Speech and Hearing Association: less than 200 members of a total of over 14,000 are black, and, in the Nation, the Association has identified only about 500 black people involved in speech and hearing therapy practice.

In part, this relative lack of representation by blacks is due to lessened opportunities to enter higher education, less information about the profession, and the depressed socioeconomic status of much of the black population. Even at predominantly black institutions of higher learning which have speech

ıtion Careers In Speech Therapy

echanism.

Dr. Harold Powell, one of many consultants to program.

pathology and audiology programs, the cost of maintaining adequately high level and comprehensive training is a severe problem, and graduates of these institutions too often are at a disadvantage when they enroll as graduate students at other institutions, as usually is necessary for continued professional participation.

It is recognized that the deficiencies in opportunity, information, and funding need to be corrected and that the effort to increase the number of black professionals in speech pathology and audiology needs to be mounted on several fronts and on a sustained basis.

A special summer program at The Pennsylvania State University was conceived as an effort in this direction. Its purposes were to stimulate career interests in speech pathology and audiology among black students from allied fields and to offer other black students already committed, to communication disorders instruction by an experienced faculty in areas of specialized interest. These specialized areas often are not available at the students' home colleges.

The Program

During each of the past three summers, 15 students from predominantly black colleges in the eastern part of the U.S. participated in the special summer program. Participants were selected on the basis of interest, scholarship, and potential to benefit from the experience at Penn State. They were already enrolled in 4-year programs leading to baccalaureate degrees, but often were not able to obtain the necessary professional courses and clinical experiences in speech pathology and audiology at their home institutions and could not afford to attend a special summer program. To attend the summer

course, the student needed the recommendation of his college advisor.

For the first 2 years, the program was sponsored by a Rehabilitation Services Administration (RSA) training grant and, for the summer of 1971, support was divided between RSA and the Bureau of Education For The Handicapped, Office of Education.

The support from federal funds provided the students with transportation from home to the Penn State campus and return, dormitory living facilities, and textbooks; they also partially supported the teaching and administration costs.

During the 7 summer weeks that the students were on campus, a wide variety of activities was planned. Travel to the campus, an orientation program, getting acclimated to the new environment, and occasionally, some preliminary academic instruction composed the first week's activity. For the following 6 weeks, students engaged in full-time study for the equivalent of six academic credits.

To expedite enrollment and to eliminate problems of university matriculation, the academic courses were handled as workshops through the continuing education program. However, the students met the usual class attendance standards, participated in lecture, laboratory, and clinical activities as expected of all university students, and were taught by senior faculty members of the university.

At summer's end the student's home school adviser was sent a statement of the student's academic experience, together with suggested academic grades. The home institution, it was understood by prior arrangement, would grant the equivalent of six academic credits toward the student's degree for the work taken at Penn State.

All students enrolled in a speech science course (the equivalent of the regular Penn State three-credit beginning course in speech science). In addition, the approximately one-third of the students not yet committed to speech pathology and audiology and interested in exploring it as a field of possible academic and professional endeavor enrolled in a survey of speech pathology course, while the students already committed to the area enrolled in a workshop course at a more advanced level. This latter group studied such areas as language disorders and cleft palate. Approximately half of the classes were in sections reserved only for the special summer students, while the other half attended class along with regular university students.

Included in the program were about 30 hours of clinical observations in the university's on-going speech and hearing therapy programs, especially in the adult therapy program, which enrolls clients of the Pennsylvania Bureau of Vocational Rehabilitation. Visits were also arranged to other clinics and programs, such as the Pennsylvania Rehabilitation Center, Pennsylvania Cleft Palate Clinics, Easter Seal Clinics, and the State Bureau of Vocational Rehabilitation.

To make the students as much a part of the university community as possible, they were housed in university dormitories along with other students. They enjoyed the rights, privileges, and responsibilities of regular university students, including library use and student union activities. Throughout each summer's program, a counselor of students was engaged to work personally with the students, to see them over difficult times, and to arrange observations, trips, and other activities related directly to the training program.

Black professionals from the field of speech pathology and audiology visited the program as consultants and spoke with the students about problems of professional development characteristic to blacks entering the profession. Dr. Harold Powell, Director of the Program at South Carolina State College, and Dr. Lovenger Bowden, formerly Associate Secretary for Urban and Ethnic Affairs of the American Speech and Hearing Association, participated in this manner.

Program Results

A Penn State faculty member visited the home institutions of the students after the first year of the program and interviewed both students and faculty. During subsequent years, a followup questionnaire was sent to former students and their faculty regarding their assessment of the program.

The Dean of Students at one of the colleges commented: "As a result of their participation in the program, several changes have been noticed in the girls' behavior. They are more aware of the opportunity and requirements of their profession and take a more active role in academic and extracurricular activities designed to improve their training . . . We are convinced that the exposure and information that they received at Penn State influenced them positively." A student adviser wrote: "Despite their lack of cooperation in some aspects of the program, the participants have been delivering only glowing reports to other students in speech pathology and audiology. They seem more aware

of the benefits of the program after it has ended than they were while they were involved in it." Still another student adviser said: "They returned with renewed vigor and vitality, plus the burning desire to go on to graduate school."

It has not been possible to do a detailed follow-up of each of the 45 students who participated in the three successive summers. However, judging from reports (such as those given above), from the records of several of the students who subsequently enrolled as graduate students at Penn State, or who were interviewed personally by the staff at a later date, there appears to be little doubt that this program has opened personal, professional, and academic doors for them, has helped many make critical decisions as to their areas of academic study, and has made it possible for others to compete successfully in training programs in speech pathology and audiology where otherwise they might have been at a very considerable disadvantage.

One of the goals of the program was to assist students not already in the field to decide about speech pathology and audiology as a possible area of study. One measure of success of the program is that each year one or more students who enrolled thinking that speech pathology and audiology was an area of interest decided by the end of the summer against entering the field. This, of course, is not a failure, because for such students it is presumed to be an enlightened career decision.

An aspect that often has been questioned in this type of program is the extent to which the special students are academically successful. As far as possible the Penn State faculty applied the same grading standards as for regular university students. In those courses where the students were integrated with regular students, the same tests were taken by all and grades were assigned on a comparative basis. Our observations are that the special summer black students demonstrate a wide range of academic achievement. Some obtained the highest grades in the class while others were among the lowest achievers in the class.

The overall average of achievement in nearly all cases was essentially equivalent to that of regular university students. The major exception was during one of the summers when the special students were enrolled in the equivalent of a graduate course in cleft palate along with graduate students of the university. The students were mixed because it was felt that it would be appropriate on a trial basis to give the more advanced undergraduate students academic training at a high level of academic challenge. The special summer students obtained, on the average, one letter grade lower than the regular students. This was not surprising because it normally would be expected that graduate students achieve at a higher level than undergraduate students.

Has the program been worthwhile? Students, their advisers, and the administrators of their home institutions think so. The Penn State faculty have found the program personally enjoyable and professionally rewarding; however, such personal and professional rewards are not the important factors. What is important is that a major northern university has participated, with federal support, in a program which attempts to fulfill a considerable need, namely helping to prepare capable black students for a profession in the rehabilitation of the speech and hearing handicapped persons. ■

GUEST LECTURERS. Undergraduate students in rehabilitation at Stout State University, Menomonie, Wisconsin, have many guest lecturers who bring up to the minute information on actual conditions in the field. Shown here is Charles Caniff, former Executive Director of the Association of Rehabilitation Centers, now IARF, receiving a certificate of appreciation from the University for a series of lectures on architectural barriers. He has spoken several times in the past 2 years. Presenting the certificate is Dr. Paul R. Hoffman, Chairman of the Department of Rehabilitation and Manpower Services. Standing, background, is Professor Henry Redkey.

Diagnosis, Retardation, AND DEAFNESS

McCay Vernon, Ph. D., and Edward Kilcullen

The magnitude and frequency of the misdiagnosis of retardation in deaf children is appalling. It is a rare State hospital that does not have at least one such patient; and public school classes for the retarded often have been used incorrectly as dumping grounds for deaf children who are not mentally deficient.[1] The problem has yet to be adequately described statistically, but the following two case histories provide some human insight into the tragedies which occur.

John D. was committed to a Southern California State hospital for the retarded at the age of 7. After 3 years there as an inpatient and additional time in a foster home placement, John was retested and found not to be retarded. He was transferred to a school for the deaf, eventually graduated, and entered Gallaudet College. It is difficult to imagine a child with college potential being institutionalized as retarded.

A girl from the same facility was hospitalized for 5 years due to an erroneous IQ of 29. A retest yielded an IQ of 113 which led to enrollment in the California School for the Deaf where she was graduated in June with a diploma from their accredited high school program. Psychologists and other professionals in the field of deafness can relate similar cases. In addition to the two persons cited above, I have come across 17 other cases in my own research and clinical work, five of whom were in one hospital.

The problem of misdiagnosis is not restricted to facilities for the retarded. In an exhaustive study by the New York Psychiatric Institute which included a survey of all deaf patients in State hospitals for the mentally ill, it was found that one-fourth of those who were also diagnosed as retarded were actually not retarded.[2] A study of Illinois hospitals yielded similar findings.[3]

What makes the problem of misdiagnosis with deaf patients especially serious is that hearing loss is more prevalent in mentally ill and mentally retarded populations.[4, 5] Fortunately, misdiagnosis is a problem which in large part can be resolved by communicating to those doing the diagnosis some relatively basic information.

Why Do Misdiagnoses Occur?

There are three major causes of the misdiagnosis of retardation in the deaf population. The first is the use of the inappropriate IQ or other tests. Verbal psychological tests are not valid with deaf subjects because they measure the language disability due to the severe loss, not intelligence. Administering a verbal IQ scale to most deaf persons is roughly analagous to measuring the IQ of Americans with a test written in French.

Thus simply by measuring intelligence with performance tests instead of by verbal scales, a high percentage of the unfortunate cases of misdiagnosis which now occur could be eliminated. Instead of spending critical early years or entire lifetimes in hospitals or classes for the retarded, these deaf persons would be able to obtain appropriate education and live relatively normal lives.

The second reason errors occur is because a significant number of deaf children have multiple handicaps.[6] Degrees of brain damage, autism, schizophrenia, aphasia, or visible physical defects, for example, are not uncommon. Any of these conditions, along with deafness, often result in test responses and behavioral patterns which are easily confused with retardation. In fact, the basic problem

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of the differential diagnosis of whether or not any of these conditions are present can be extremely difficult in certain cases.The problem is further compounded because autism, brain damage, and aphasia are known to be more common in the deaf population.[7]

The difficulty of differential diagnosis can be shown through the case of Lyman R., the deaf son of deaf parents. He had two deaf sisters, one of whom went to college. At the time of testing, Lyman was 15 years old. He had no verbal language system. On most subtests of the WISC, he received scaled scores of two or three, but on the Block Designs, Lyman did every item right in the minimum time allowed. Neither of the authors of this paper and few of the readers could do this well. Is this patient an idiot savant, a retardate, autistic, schizophrenic, brain damaged, aphasic, or all of these? Even today, now that Lyman is 22 years of age, the best psychological and psychiatric facilities of California have not been able to agree on a diagnosis. He has been hospitalized as both a retardate and as a psychotic without retardation.

In almost every hospital for the mentally ill or mentally retarded there are similar cases. Relative to retardation and to deafness the important point is that these other problems, if present in a deaf child, can lead to a diagnosis of mental deficiency when it is indeed incorrect.

A final factor that leads to frequent misdiagnosis is that most persons who are deaf (in terms of the functional value of their hearing) still retain enough sound perception to respond to certain noises. Sometimes when these deaf children or adults are seen to react to sound, they are assumed not to be deaf. Their language disability and failure to cope with spoken questions is then misinterpreted as lack of intelligence, instead of a normal consequence of severe hearing loss.

In sum, misdiagnoses occur primarily due to: (1) the use of verbal tests instead of performance tests, (2) the presence of other physical or psychological pathologies which mimic retardation or otherwise confuse diagnosis, and (3) the failure to identify as deaf those patients with residual hearing that is essentially nonfunctional for communication. Group testing, the unreliability of any tests used with young children, inexperienced examiners, and the failure to recognize the linguistic limitations of many hard of hearing children are other conditions which can lead to the hearing impaired being misclassified as retarded.

Table 1

Leading Etiologies of Deafness in Children*

Etiology	*Estimated range of prevalance*
Genetics	40 to 60%
Complications of Rh Factor	3 to 4%
Meningitis	9 to 10%
Prenatal Rubella	5 to 85%
Premature birth	11 to 17%

*An epidemic disease. Therefore, incidence figures vary greatly from year to year.

Some advocates of behavioral modification may argue that diagnosis is unimportant. Theoretically, this may be a defensible argument. Yet, from a pragmatic viewpoint, diagnosis is crucial because it often determines placement and therapy. For example, diagnostic classification often determines whether a child goes to school, is hospitalized as a retardate, or is sent to a facility for the mentally ill. The treatments in these three types of facilities vary drastically as they bear on the future life of the child.

Deafness and Retardation

To describe the relationship of deafness to retardation requires a reconsideration of the relationship of the distribution of IQ in the general population to the normal probability curve. While intelligence is essentially normally distributed among hearing people an exception occurs at the lower end of the curve where there is a sort of "bubble." [8] Stated in statistical terminology the curve for IQ has a very slight bimodal characteristic, the smaller maxima of very low elevation being below the 70 IQ cut off. This "bubble" is due to certain genetic factors such as PKU or Rh blood incompatibility and to epidemical diseases such as prenatal rubella. All of these conditions contribute to a disproportionately large percentage of the population being retarded.

It is necessary to bring this rather complex phenomenon to attention because it is directly relevant to retardation and deafness. Although IQ is essentially normally distributed in the deaf population, the "bubble" at the lower end, i.e. within the IQ range of retardation, is somewhat larger.[9] The reason for this is that the leading etiologies of deafness are also major causes of retardation. Prenatal rubella, complications of Rh factor, meningitis, and

Table 2

Patients With and Without Hearing Handicap
by Degree of Handicap by Hospital (with percentages)
Maryland State Hospitals for the Retarded
1968

Degree of handicap	Both hospitals		Rosewood		Henryton	
	Number	Percent	Number	Percent	Number	Percent
ALL PATIENTS	3,181	100.0	2,810	100.0	371	100.0
No handicap, hearing apparently normal	2,720	85.5	2,393	85.2	327	88.1
Total with handicap or handicapping condition, all degrees	461	14.5	417	14.8	44	11.9
Some hearing problem, mild	174	5.4	136	4.8	38	10.2
Severe hearing problem	17	.5	16	.6	1	.3
Some problem, degree not determined	113	3.6	110	3.9	3	.8
Apparently totally deaf	44	1.4	43	1.5	1	.3
Hearing cannot be determined	113	3.6	112	4.0	1	.3

premature birth account for at least a third of all deafness in children.[10] Each of these conditions is also associated with retardation. Genetic factors, which cause about half of childhood deafness, sometimes result in syndromes involving both hearing loss and retardation.[11] Usher's syndrome, which is congenital deafness and progressive blindness, is an example.[12] Twenty-five percent of those having Usher's syndrome are retarded. (See table 1.)

Education And Training

Not only is there probably somewhat more retardation among deaf persons, but from a functional viewpoint deafness tends to compound the problem of the retardation. Unless the deaf child of low IQ is given adequate education or training, he is not as likely as the hearing child to function to the full capacity of the intelligence he has.

At present there is a gross lack of educational and training opportunities, not just for deaf persons with IQs below 70, but for all deaf children of IQ 85 or 90 and below.

Deaf Patients In Hospitals For The Retarded

What is known about hospitalized deaf retardates? There have been some reports of rehabilitation efforts and some surveys which have appeared in the literature.[13, 14] Recently, Mr. Edward Kilcullen, coauthor of this paper, investigated the situation in

Table 3

Approximation of Degree of Hearing Loss
of the Hospitalized Hearing Impaired Retarded
Population of Maryland
N=461

Estimated degree of hearing loss	Prevalance	
	Number	Percent
Deaf	32	6.9
Severe hearing problem (cannot understand speech)	43	9.3
Observable or measurable hearing loss, but not severe	118	23.6
Hearing loss established but degree unknown	268	58.1

Table 4

IQ of Hearing Impaired
Population of Rosewood
Hospital for the Retarded
Maryland
N=319

Degree of retardation	Prevalance	
	Number	Percent
IQ 70–79	3	0.9
IQ 50–69	29	9.1
IQ 25–49	105	32.9
IQ 0–24	182	57.3

Maryland hospitals for the retarded. His findings (reported in Table 2) indicate 15 percent of the patients had significant measurable hearing loss

as determined by rough audiological screening procedures done primarily by hospital nurses. A 1958 review of such surveys [15] reported approximately similar results. (See Table 2.)

Further analysis of this 15 percent (461 hearing impaired patients) indicated that about 16 percent of them can be identified as deaf for practical purposes of communication. Of the total of 461 there were IQs available on 319 who were in Rosewood Hospital. About 9 percent of these are in the educable range (IQ 50–69) and approximately 1 percent had IQs above 70. (See Tables 3 and 4.)

The intent in reporting these data is to give a picture of the retarded, hearing impaired population as seen by hospital staff themselves. Had the data been obtained by audiologists and psychologists experienced in testing deaf subjects, there is no doubt that a different picture would have resulted.

Deaf children and adults are frequently misdiagnosed as mentally retarded or mentally ill with appalling results in terms of their human rights and life circumstances. Simply by using non-verbal psychological tests—especially IQ scales—and recognizing that the deaf persons' linguistic and communication limitations are usually a function of their hearing loss, and not due to psychopathology or retardation, much of this misdiagnosis can be avoided.

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New Publications

(Continued from page 19.)

for the adult deaf and examines specific programs in such places as Washington, D.C., Flint, Michigan, Los Angeles, and in Wisconsin.

The findings of several discussion groups occupy the second part of the book. The topics include the meaning of continuing education, organizing for full community support, staff and resource needs, and evaluations of programs.

Distance Vision and Perceptual Training. Loyal E. Apple and Marianne May. American Foundation For The Blind, Inc., 15 West 16th St., New York, N.Y. 10011. 23 pages. $2.25.

This monograph deals with the special orientation and mobility problems of persons with residual vision. It also presents an annotated reading list about the development of mobility programs for these clients.

Your Child Has A Learning Disability . . . What Is It? Beverly S. Williams. National Easter Seal Society For Crippled Children and Adults, 2023 W. Ogden Ave., Chicago, Ill. 60612. 16 pages. 15 cents.

The author writes in layman's language to describe symptoms of learning disability, to emphasize the need for early identification, and to give remedial suggestions for application at home and school. Her guidance lends encouragement and hope that a child with a learning disability can become a self-sufficient adult if given special considerations.

Brief Therapies. Harvey H. Barten, M.D., editor. Behavioral Publications, 2852 Broadway, Morningside Heights, New York, N.Y. 10025. 342 pages. $9.95.

Brief psychotherapeutic approaches are described, such as crisis intervention, short term group and family therapy, family crisis therapy, multiple family groups, and short hospitalizations. The techniques, abundantly illustrated by case histories, are aimed at a variety of patients, including children, adolescents, and patients with many psychiatric problems.

WORK EXPERIENCE: TRANSITION FROM SCHOOL TO EMPLOYMENT FOR MENTALLY RETARDED YOUTH. (RD 2058) Vocational Guidance and Rehabilitation Services, 2239 East 55th St., Cleveland, Ohio 44103. 54 pages.

EXPLORATORY AND EVALUATIVE RESEARCH IN THE VOCATIONAL ADJUSTMENT OF THE HANDICAPPED. (RD 1949) Human Resources Center, Albertson, N.Y. 11507. 36 pages.

FROM HOSPITAL TO COMMUNITY: A SELF-HELP PROGRAM TO PROMOTE THE TRANSITION. (RD 1924) Albert Einstein College of Medicine of Yeshiva University, Bronx, N.Y. 10461. 115 pages.

EVALUATION, SELECTION AND FITTING OF MONAURAL AND BINAURAL HEARING AIDS FOR MIDDLE AND OLD AGE HARD OF HEARING PERSONS. (RD 501) Research Foundation, State University of New York, P.O. Box 7126, Albany, N.Y. 12224. 155 pages.

AUDITORY PERCEPTION IN CHILDREN. (RD 2574) University of Southern California, Los Angeles, Calif. 90007. 58 pages.

OCCUPATIONAL TRAINING AND EVALUATION CENTER FOR THE MENTALLY RETARDED. (RD 1546) Benevolent and Protective Order of Elks, Lodge #242, Lockwood Blvd., Charleston, S.C. 29401. 31 pages.

TACTILE TELEVISION—MECHANICAL AND ELECTRICAL IMAGE PROJECTION. (RD 2444) Institute of Medical Sciences, 2361 Clay St., San Francisco, Calif. 94115. 64 pages.

THE PERCEPTIONS OF IMPLICATIVE RELATIONSHIPS AMONG BLACK AND WHITE ADOLESCENTS AND THE HARDCORE UNEMPLOYED. (RD 2841) University of Illinois, Group Effectiveness Research Laboratory, 909 West Nevada St., Urbana, Ill. 61301. 193 pages.

A STUDY OF REHABILITATION POTENTIAL IN ARTHRITIS THROUGH PROGRAMED ANALYSIS. (RD 3035) The George Washington University, Washington, D.C. 20006. 205 pages.

ROLE PERCEPTIONS AMONG BLACK AND WHITE ADOLESCENTS AND THE HARDCORE UNEMPLOYED. (12–P–55175) 32 pages. JOB PERCEPTIONS AMONG BLACK AND WHITE ADOLESCENTS AND THE HARDCORE UNEMPLOYED. 21 pages. Department of Psychology, University of Illinois at Urbana-Champaign, Urbana, Ill. 61801.

EVOKED CORTICAL POTENTIALS IN APHASIA. (RD 2834) University of Minnesota, Minneapolis, Minn. 55455. 26 pages.

FLAME OF HOPE—NEW APPROACHES TO COMPETITIVE EMPLOYMENT OF THE MENTALLY RETARDED THROUGH PROPRIETARY PRODUCTS. (RD 2686) Flame of Hope, Inc., Scudder Ave., Hyannis Port, Mass. 02647. 110 pages.

SPECIAL VEHICLES FOR THE SEVERELY DISABLED. (RD 2615) Regents of the University of California, Campus Research Office, 250 Sproul Hall, University of California, Berkeley, Calif. 94720. 31 pages.

BIOMEDICAL ENGINEERING IN PHYSICAL REHABILITATION. (RD 2604) Regents of University of Michigan, 2008 Administration Building, Ann Arbor, Mich. 48104. 158 pages.

MAXILLOFACIAL PROSTHETICS. (RD 2431) Health Research, 666 Elm St., Buffalo, N.Y. 14203. 54 pages.

VOCATIONAL REHABILITATION OF DISABLED PUBLIC ASSISTANCE CLIENTS. (RD 1514) Division of Vocational Rehabilitation, 400 Atlas Building, 36 West Second South, Salt Lake City, Utah 84101. 82 pages.

THE PATHOMECHANICS OF ULNAR DRIFT—A BIOMECHANICAL AND CLINICAL STUDY. (RD 2226) The University of Iowa, Iowa City, Iowa 52240. 145 pages.

VOCATIONAL REHABILITATION OF THE MENTALLY RETARDED ADULT: REPORT OF A DEMONSTRATION PROJECT FEATURING AN INTERGENERATIONAL RELATIONSHIP. (RD 2346) Federation Employment and Guidance Service, 215 Park Ave., S. New York, N.Y. 10003. 55 pages.

TO DETERMINE THE FEASIBILITY OF SHELTERED WORKSHOP IN RURAL MINNESOTA. (RD 735) Lake Region Sheltered Workshop, Inc., 201 North Whitford, Fergus Falls, Minn. 56537. 74 pages.

A PROJECT TO DETERMINE THE EMPLOYABILITY OF EPILEPTICS. (RD 253) Epi-Hab Phoenix, Inc. 2125 West Fillmore, Phoenix, Ariz. 85009. 24 pages.

HABILITATION OF DEAF YOUNG ADULTS. (RD 1804) Jewish Employment & Vocational Service, 1727 Locust St., St. Louis, Mo. 63103. 73 pages.

LEARNING BY DOING. (RD 55188) Jewish Vocational Service, Chicago, Ill. 60606. 54 pages.

PIONEER VILLAGE—PREVENTION OF POTENTIAL JUVENILE DELINQUENCY THROUGH CAMPING. (RD 55013) Kiddie Kamp Corporation, 419 Boylston St., Boston, Mass. 02116. 125 pages.

REMEDIATION OF COORDINATION DEFICITS IN YOUTH WITH MINIMAL CEREBRAL DYSFUNCTION. (RD

55120) The Devereux Foundation, Devon, Pa. 19333. 163 pages.

A COMPREHENSIVE STUDY OF THE REHABILITATION PROCESS IN PATIENTS IN A CHRONIC DIALYSIS PROGRAM. (RD 2143) University of Alabama, Birmingham, Ala. 35233. 121 pages.

WHEELCHAIRMANSHIP PROJECT. (RD 55193) The American Rehabilitation Foundation, 1800 Chicago Ave., Minneapolis, Minn. 55404. 171 pages.

NEW APPROACHES TO THE DELIVERY OF TOTAL SERVICES FOR BLIND PEOPLE. (RD 55132) The Virginia Commission for the Visually Handicapped, 3003 Parkwood Ave., Richmond, Va. 23221. 55 pages.

LOS ANGELES SERVICES TO THE HOMEBOUND. (RD 55293) Industrial Services, Inc., 1400 Newton St., Los Angeles, Calif. 90021. 37 pages.

INFORMATION-EXCHANGE PROGRAM FOR REHABILITATION RESEARCH AND TRAINING CENTERS—A FEASIBILITY STUDY. (RD 3714) Biological Sciences Communication Project, Medical Center, The George Washington University, 2000 P St., NW., Washington, D.C. 20036. 61 pages.

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The Wagner O'Day Act Amendments: Implications For Sheltered Workshops

Michael M. Dolnick and William M. Usdane, Ph. D.

Lack of contract work on a sustained and regular basis is a major problem of sheltered workshops. A continuous flow of work is necessary to keep employees productively engaged and to maintain the workshop's rehabilitation services since work, along with supportive rehabilitative services, is the means by which the workshop accomplishes its objectives. Inability to provide this employment defeats the very purpose of the workshop's existence.

Most workshop directors, even those employing full time salesmen, devote considerable effort to the procurement of contract work. Ever since 1938 when the Wagner O'Day Act was enacted to provide employment opportunities for the blind in the manufacture of products to be sold to the Federal Government, leaders in the workshop field serving the nonblind have been hopeful that this same preferential treatment would be extended to all facilities serving all types of disabled persons. It was anticipated that the vast resources and needs of the Government would afford a solution to the "feast or famine" situation that many workshops faced. With the Federal Government as a major customer and dependable purchaser, workshop directors and other key personnel would be able to devote more time to rehabilitation and management functions.

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The Wagner O'Day Act of June 25, 1938 made it mandatory for all government agencies to purchase certain items from qualified agencies for the blind. The Committee on Purchase of Blind-Made Products, created by the Act, selected the items which were published in catalog form, known as the "Schedule." The Committee also established a fair market price for the items. The price could vary, however, as market conditions changed.

A nonprofit agency, The National Industries for the Blind, was created in 1938 to deal with government purchasing offices and to distribute the purchase orders to the nonprofit workshops for the blind enrolled in the program. There are now 81 workshops in 36 States affiliated with the organization. They employ 500 blind workers and produce 435 items for the government. Gross volume sales has been as high as $28 million a year.

In its 33 years the program has seen thousands of blind workers employed; upon entry 80 percent of them had been receiving assistance in some form. Approximately 15,000 have passed from the public assistance rolls into workshops and then into competitive employment.

On August 1, 1971, the eagerly awaited amendments to the Wagner O'Day Act became effective, ending a long campaign on the part of the leadership of the workshop movement to update the law. The two principal changes were to extend the spe-

cial priority in selling certain products to the Federal Government now reserved for the blind to other severely handicapped persons and to expand the category of contracts to include "services." Organizations for the blind will continue to have first preference on the sale of commodities and, until December 31, 1976, on the contracting of services. After that date, all nonprofit organizations serving the handicapped will receive equal treatment in the awarding of contracts for services which will include such diverse activities as cleaning and maintenance services, printing, automatic data processing, packaging, lettershop services, assembling, and any of the varied service functions now performed by workshops.

There were other significant changes. The seven-member committee was expanded to 14 to take into account representatives from government departments that did not exist in 1938 and to increase the number of public members from one to three. Provision is made for the appointment of the members, reappointment eligibility, the filling of membership vacancies, and for staggered 5-year terms for the public members. The public members are now compensated on a per diem basis and for travel expenses.

Of great importance is the provision for staff, subject to Civil Service regulations, who will function at the direction of the Committee. In the past, personnel were detailed for part of their time from the agencies and departments represented on the Committee. The new Committee may still use detailed personnel of any unit of the government but on a reimbursable basis. An annual report is required, giving a description of activities and recommendations concerning the operation of the Act. This Committee, unlike other appointive bodies, has specific operating and program responsibilities; it is not merely advisory.

To discharge its responsibilities, it must conduct a vigorous program for the addition of new items and services. It must have the capability to examine the qualifications and capabilities of workshops proposing to enter the program. It must also have the capability to monitor and audit the performance of workshops supplying commodities and services.

As indicated previously, the amendments to the Act extend coverage to the severely handicapped who are defined as persons or classes of individuals under a physical or mental disability (other than blindness) which (according to criteria established by the Committee after consultation with appropriate government agencies, and taking into account the views of private agencies representing the handicapped) constitutes a substantial handicap to employment and is of such a nature as to prevent the individual under such disability from engaging in normal competitive employment. The Committee is currently developing these criteria.

Subsection (c) of the Act directs the Committee to designate a central agency or agencies to facilitate the distribution of orders of the Government for services and commodities. As of this time, the Committee has decided not to designate a single or new counterpart agency to the National Industries for the Blind for allocating contracts to workshops serving the other severely handicapped. The Committee will work with existing national organizations and has asked them to designate representatives to serve on a products evaluation committee. The future direction of the contract allocation mechanism remains flexible and is subject to changes.

Committee and workshop needs cannot be met by the very limited staff which is available to the Committee. Other organizations will have to assist in supplying these needs as NIB has been doing in the past. The principal functions involved are these:

- Evaluating workshop qualifications and capabilities and guiding them to the point of being able to supply assigned items or services successfully,
- Participating on behalf of individual workshops in the evaluation and assignment of new items and services,
- Managing the actual assignment of orders to participating workshops,
- Assisting workshops throughout filling of the orders,
- Initiating requests for repricing items and services, as appropriate.

The President announced the appointment of 13 persons as members of the Committee for Purchase of Products and Services of the Blind and Other Severely Handicapped. The appointees are: Tony M. Baldauf, Department of Agriculture; Lt. General Wallace H. Robinson, Jr., USMC, Department of Defense; Col. Marco J. Caraccia, Department of the Army; Rear Admiral K. R. Wheeler, SC, USN,

Department of the Navy; Brig. General Jonas L. Blank, USAF, Department of the Air Force; William M. Usdane, Department of Health, Education and Welfare; Anthony A. Bertsch, Department of Commerce; Donald P. Whitworth, Jr., Veterans Administration; J. J. Clark, Department of Justice; Horace E. Menasco, Department of Labor; and three members from the public-at-large: Thomas C. Hasbrook, Indianapolis; Anne H. Carlsen, Ph. D., Jamestown, N.D.; and Jansen Noyes, Jr., Darien, Conn.

These members will be joined by a member from the General Services Administration, to bring the total committee strength to 14 persons.

The House of Representatives' Committee on Government Operations, astutely aware of the relationship of this Act to HEW's mission of rehabilitating the handicapped, incorporated the following language in its Report No. 92–228 issued on May 25, 1971:

. . . The Committee on Government Operations expects that the Department of Health, Education, and Welfare will utilize its resources to a greater degree, especially the Department's Rehabilitation Services Administration (RSA), to assist the Committee and the central nonprofit agency or agencies created under this Act—such as the National Industries for the Blind—to provide the work effort to expand the number of products and services on the priority procurement list.

The Committee on Government Operations further indicated its interest in the rehabilitation of handicapped persons and their movement into industry by specifically charging RSA in these words with the responsibility for monitoring this activity: "RSA should utilize its resources for monitoring and evaluating the Wagner O'Day program in its effectiveness in rehabilitating handicapped people into competitive employment."

At this time it has not been exactly determined how RSA will implement these Congressional directives, but recommendations relating to these responsibilities will be secured from the National Policy and Performance Council. This Council is a statutory body created by the 1965 amendments to the Vocational Rehabilitation Act to advise the Secretary with respect to policies and criteria relating to training services grants and workshop improvement. The monitoring of the workshop's performance under the Wagner O'Day Act and its effect on rehabilitation of the handicapped appears to be an additional activity within the realm of the Council's responsibility.

The Wagner O'Day Act is no panacea. Workshop directors who believe that their contract solicitation efforts can now be ended and that government contracts will automatically pour in merely by indicating availability and interest in receiving assistance are due for great disappointments. Financial need, worthy causes or "doing good work for the handicapped" will not be considerations in the government purchase of goods or services for workshops. Workshops that do not have the capability of performing according to government requirements of quality control and delivery schedules may find that it is more difficult to receive a government purchase order than for an undeveloped country to receive foreign aid!

A most important field where workshop capability needs to be developed is that of automatic data processing. No one can fully comprehend how large this potential source of government purchases will be and the workshop movement should be fully cognizant of the need to develop its capacity to perform these services and to enlarge its training efforts in these skills.

The International Association of Rehabilitation Facilities is planning a series of training services on the implementation of the Wagner O'Day Amend-

University Image

The university has sold itself to the public as a veritable panacea for personal and social problems, playing on the credulous notion that processing everyone through ivy covered buildings for four years was "education" and therefore "a good thing." Its pretensions have been greatly helped by the fact that even the worst education cannot prevent students from growing four years older in the course of four years, and that it is rare for a young adult not to acquire some elements of maturity and miscellaneous information over such a span of time.

—From a paper, "The Available University" by Thomas Sowell, printed in The University of Chicago Magazine, *November 1970.*

Some of the members and staff at a recent meeting of the Committee for Purchase of Products and Services of the Blind and Other Severely Handicapped are pictured. Left to right: Donald Whitworth; BRIG GEN Jonas L. Blank; Anthony A. Bertsch; Warren D. Landis; Beverly Hackett; Leamon F. Donahue; RADM Kenneth R. Wheeler; Hart T. Mankin; John J. Clark; COL Marco J. Caraccia; LTGEN Wallace H. Robinson, Jr.; Harold Scheller; and Dr. Willaim M. Usdane.

ments as they pertain to nonblind rehabilitation facilities. One conference has been conducted.

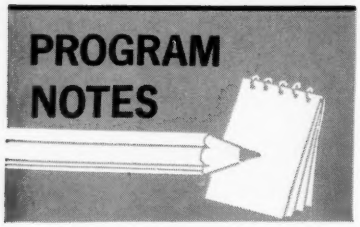
Several of the university programs for the training of sheltered workshop administrators are offering short term institutes on specific production, engineering, and management subjects. The University of Maryland, for example, offers an interesting training program in three separate sessions that includes 3 days covering production principles, 4 days of training in a pre-determined time standard of pricing contracts, and 1 day on followup and problem solving. The sessions are spaced so that busy workshop personnel need not be absent from their workshops for extended periods of time. Other similar short term training institutes and on other subjects are conducted by the University of San Francisco; De Paul University, Chicago, Ill.; Stout State University, Menomonie, Wis.; the University of Arizona; Wayne State University, Detroit, Mich.; North Texas State University, Denton, Tex.; and the Vocational Guidance and Rehabilitation Service, Cleveland, Ohio.

A most significant resource to assist workshops in improving their capability is the federal technical assistance program authorized by the Vocational Rehabilitation Act. Under 100 percent Federal funding, it provides short term consultant services to rehabilitation facilities. During the past fiscal year, 150 consultants, primarily employed in industry and serving on a contract basis, provided 400 consultations to rehabilitation facilities enabling them to strengthen their operations and improve their efficiency. One third of the consultations were in the area of program development, one third in industrial engineering, production, and safety, and one third in the area of administration, management, services, and accounting.

Areas in which many workshops will need improvement include accounting and costing, quality control, materials handling, purchasing, warehousing, estimating and bidding, and production.

The Act states that purchases must be made from a "qualified" not just a nonprofit agency for the blind or severely handicapped. The combined resources of the Government and private sectors are pledged to assisting sheltered workshops to become qualified and to enable them to utilize this new resource which could conceivably prove to be one of the most significant developments in the workshop movement during recent times.

All of the above content has stressed the need for improved industrial capability on the part of most workshops. However, we must constantly be aware of the fact that a workshop is not a factory and that its principal business is rehabilitation. Overemphasis on the industrial aspects of sheltered workshop operations at the expense of or to the neglect of the workshop's rehabilitation functions can lead to the development of a factory-type operation that provides little incentive for transition into competitive employment. Some day, long-overdue recognition will be given to those workshop directors who have achieved a proper balance in a facility that provides excellent rehabilitation services and also operates at the same level of industrial efficiency as its profit-making counterpart.



Rehab Needs Studied By International Group

• Rehabilitation International, a non-governmental federation of voluntary organizations in 62 countries, is exploring ways of bringing rehabilitation services into countries where these services are inadequate or non-existent. The 3-year project is supported in part through an SRS Research Utilization grant.

A central resource service is being planned to collect and evaluate information about services in various countries, to store and retrieve reference data, and disseminate complete and up-to-date information to individuals and institutions.

The project also is examining methods of attracting, training and keeping personnel and strengthening eixsting services through the exchange of international experience. Teams of outside experts are being sent into selected countries, commissions have been formed to provide technical guidance, and several international conferences were scheduled in late 1971 to offer an additional forum for the exchange of ideas.

Abstract to Document Rubella-Related Disabilities

• In what might be termed a preventive rehabilitation project, SRS is supporting a study by the Excerpta Medica Foundation and Gallaudet College to collect 2,000 rubella abstracts that will provide information on the educational, medical, rehabilitation and social service areas, as they apply to the after effects of this disease.

The need for this kind of reference arises from the expected after-effects of the 1963–1965 rubella epidemic which saw an estimated 30,000 to 50,000 children born with handicaps ranging from hearing impairments to visual problems and mental retardation.

The full impact of the epidemic becomes even greater as this large block of children matures. The study hopes to collect and organize this information on the various aspects of helping these children as they come of age, with final emphasis on their vocational training.

Spiral, Plastic Orthoses Undergo Rigid Testing

• Scientists at the Institute of Rehabilitation Medicine at New York University Medical Center are designing and testing new types of lower extremity orthoses that are both light and cosmetic in appearance. (See program note, *Rehabilitation Record,* March–April 1970, page 9.) One of the devices is a spiral, plastic, below-the-knee brace that winds and unwinds as a person walks. The device is thin and, therefore, is light and is easily covered by stockings or slacks.

Because of construction and type of material, the breakage point of the orthoses becomes a vital factor in its construction. Three versions of the brace were tested and each new version has withstood greater stress, with the first failing at close to 600,000 cycles, the second at over 2 million, and the third did not fail with close to 5 million cycles. The researchers state that these stress tests were conducted under "normal" conditions and that overstressing tests will be run to determine conditions that equate walking down stairs or other overstress situations on the orthosis.

The strength of the plastic material itself has come under investigation. The investigators have looked into the fabrication of the orthoses using heat treatment and radiation treatment in the fusing of the plastic material. They have also looked into injection molding of the device (not feasible), and its prefabrication through a milling process.

California Counselor Helps Organize Course For Blind

• The vocation of medical transcriber long has been recognized as a suitable vocational goal for the blind. Robert A. Nesler, a vocational rehabilitation counselor in the San Francisco Office of the California State Department of Rehabilitation, realized the need for training in this area. Since the only instruction available was through private tutoring, Nesler spearheaded a public adult school training program for the blind. The program is expected to save the department about $45,000 in case service money.

Eighteen visually impaired rehab students are now enrolled in the classes. Classes are conducted by the John Adams Adult School, with the school providing space and equipment and the Adult Education Program paying the teacher's salary. Originally, the teacher's salary was paid by the Department of Rehabilitation.

The course offers typing and business English and leads to qualifying as medical transcribers, typists, and receptionists.

Blind Reader Service Income Tax Deductible

• The Internal Revenue Service has ruled that the unreimbursed cost of reader services for a blind person may be deducted from the income tax as a medical expense.

The cost of services in excess of 3 percent of the adjusted gross income may be deducted in computing the annual federal income tax.

Sheltered Workshops in Sweden

John R. Kimberly

As a visitor to Sweden who wished to learn about the general characteristics of sheltered workshops in that country but who had only a limited amount of time to spend, I was fortunate to have made contact with the Vocational Rehabilitation Division (VRD) of the Swedish National Labor Market Board (NLMB) in Stockholm. Each year hundreds of visitors are introduced to Swedish labor market policy and rehabilitation programing by the agency's capable, multilingual staff. The observations made here are one outcome of a program arranged by the VRD for me as part of a project entitled "Organizations and Services for the Disadvantaged in the United States and Sweden." It was sponsored, in part, by the Center for International Comparative Studies, University of Illinois.

It is difficult to make direct comparisons between Swedish and American experiences regarding sheltered workshops. First of all, there are some important differences between the two countries. Sweden has a population of approximately 8 million, one twenty-fifth that of the U.S. While in many respects the standard of living in Sweden approximates ours, the population is ethnically much more homogenous. Striking differences in social and economic policy can be observed, a consequence of Sweden's commitment to the Social Democratic vision of the welfare state.

The author, formerly a research associate at the Region II Rehabilitation Research Institute, Cornell University, is currently an assistant professor of sociology and labor and industrial relations at the University of Illinois in Urbana.

Further caution in making such comparisons is suggested by the limited amount of time spent collecting the information presented here, approximately 5 weeks. What this article is designed to do, then, is to present the reader with a descriptive overview of sheltered workshops in Sweden, an overview which hopefully will provide both an indication of the current level of development of these organizations and a sensitivity to some of the issues that are currently being raised regarding their operation.

Any discussion of sheltered workshops in Sweden would be incomplete without an understanding, in general terms at least, of their development historically and how they fit into the context of Swedens welfare state. In 1943 a special government committee was established by the Minister of Social Affairs and was given the task of investigating and proposing solutions to the problems of the disabled. The work of this committee, contained in five reports published between 1946 and 1948, resulted in the establishment of a set of principles for serving the disabled. It laid the groundwork for today's elaborate network of organizations.

In terms of understanding the role of sheltered workshops in this network, two outcomes of the committee's work are of particular importance. First, the committee defined a disabled or "partially able-bodied" person as one who "owing to physical or mental defect or social hindrance has more difficulty than others to obtain or keep work." Second, it suggested that all efforts to serve the disabled

should be administered through a special office of the State Employment Board, the name of which was later changed to the National Labor Market Board to reflect its broad-based concerns with all aspects of labor market policy.

The implications of these two outcomes are profound. Not only was disability defined in labor market terms, but "social hindrances" were specifically included within the scope of the definition. In addition, efforts to serve the disabled were to be administered by an organization whose function was to administer labor market policy in general. What the outside observer should be aware of, therefore, is that sheltered workshops in Sweden constitute one set of organizational responses to labor market questions. As such, their growth and development is heavily influenced by a policy the basic ingredient of which is a commitment to full employment and the basic philosophical cornerstone of which is the principle that every individual should have the right to work and earn a living. As the vehicle for implementing this policy, the Government has the primary responsibility for ensuring that no categories of individuals are deprived of the possibility of earning a living.

The exceptionally strong commitment to full employment has led to the formulation of a series of programs of national scope, developed and administered by the Government but generally operated with a good deal of local autonomy, designed to maintain high levels of employment. To understand the role of sheltered workshops, therefore, one must realize that they are an integral part of a broad-based, national manpower policy.

Also there is an important distinction to be drawn between *sheltered employment* and *sheltered workshops*. Workshops are just one form of sheltered employment. Other forms include outdoor relief work, home work, semisheltered employment, and archive work, all of which are described in Beatrice Rubens' book, *The Hard to Employ: European Programs.* To provide an indication of just what role sheltered workshops play in sheltered employment as a whole, in June of 1971, approximately 12,000—somewhat less than 40 percent—of the 33,000 places in sheltered employment were accounted for by sheltered workshops. As one attempts to make comparisons with programs in the U.S. and other countries, this important distinction should be borne in mind.

Currently, there are some 255 workshops in the country. Of that total, approximately 35 are workshops for the mentally retarded. Compared to those in Holland, workshops in Sweden are small. The average number of clients places per shop is 47, and, according to figures for 1968, 44 percent of the shops have fewer than 25 places, while only 6 percent have 100 places or more. The figures for Sweden are more comparable to those in this country, where 50 percent of all workshops serve fewer than 45 clients per day, than they are to those in Holland, where more than 65 percent of the workshops serve over 100 clients, according to Dolnick's observations. (*Rehabilitation Record,* March–April 1971.) Clearly, questions regarding possible economies of scale in workshop operations might usefully be pursued on a comparative basis using the experiences in Sweden, Holland, and the U.S. as a point of departure.

A wide variety of disabilities is served. According to figures for 1968, which do not include workshops for the retarded, 28 percent of the clients employed were classified as orthopedically handicapped, 33 percent mentally ill, 8 percent alcoholics, 3 percent blind, 3 percent socially maladjusted, and 24 percent suffering from "other somatic" disabilities. Since 1968, however, a new set of categories for defining disabling conditions has been developed and implemented by the Government for reporting statistics. This classification scheme has 15 categories corresponding more closely to internationally accepted definitions. Its use will permit more general comparisons of client disabilities across countries.

As is the case here, workshops in Sweden vary considerably in the technological sophistication of their work processes. Some of the larger shops use highly sophisticated equipment in a highly automated setting, equipment which requires substantial amounts of capital investment. Of particular interest was a new paper cutter for trimming printed pages of books. It could be programed in advance to perform a variety of operations. I saw it in use in an ultra-modern workshop in a suburb of Stockholm. This shop also had a large amount of up-to-the-minute printing equipment designed to meet a variety of customer demands. Also impressive was an automated furniture lacquering machine which could put the finishing touches at very high speeds on a variety of items of furniture. Many of these shops closely resemble successful business organizations in many respects. Often they are given names which do not indicate that they employ disabled persons.

To qualify for governmental subsidies, a workshop must have a qualified medical consultant for a cer-

tain number of hours per month. Other kinds of professional services, such as rehabilitation counseling, psychological testing, vocational evaluation, and psychiatric social work, are not, in most cases, available in the workshops *per se* but are provided by State agencies outside.

Prior to being admitted, a client generally has been extensively tested and may have received professional services from a variety of other vocational rehabilitation, medical rehabilitation, social welfare, or mental health agencies. Evaluation services, for example, modeled after procedures developed at the National Clinic for the Assessment of Work Capacity in Stockholm and currently being expanded, are available through the VRD.

Typically, the staff of a workshop will consist of a manager and a number of supervisors contingent on the number of clients being served. Generally workshop staff are drawn from industry and have little or no formal background in rehabilitation.

As with professional services, placement services are coordinated by other government agencies, and, as a rule, workshops themselves do not have any regular placement activities. Generally, referral to a workshop is made only after placement possibilities in industry have been exhausted by the local offices of the county labor boards. Most local offices have a disablement resettlement officer on the staff whose basic task is to provide services to the disabled. It is he who makes the decision to refer particular cases to the workshop. While many workshop managers encourage the placement of their clients in industry, national figures indicate that on the average, per year, only about 3 to 5 percent are actually placed in industry.

Wages are paid on the basis of the prevailing rate received by municipal workers in the area, a rate which is fixed by collective agreements. While the bonus system found in the Netherlands does not exist in Sweden, there is an increasing interest in exploring the possibilities of pegging client wages to those received by trade unions in the community whose members perform work similar to that done in the workshop. Such a system, however, is primarily in the discussion stage. It has not been widely implemented. Given the tradition of close cooperation between the Swedish Trade Union Confederation, the largest in the country, the Government on matters of social and economic policy, and given the increasing interest shown by some trade unions in sheltered employment, it would not be surprising to see more intensive explorations of the role of trade unionism in sheltered employment, and workshops in particular, in the near future.

Earlier, the role of sheltered workshops in the context of national manpower programing was noted. As might be expected, given this role, the Government subsidizes a variety of workshop activities. The basic nature of these subsidies was established by Royal Ordinance 370, which became law in June of 1966, and subsequent amendments thereto. To be eligible, a workshop must have the services of a qualified medical consultant, employ a manager with qualifications meeting standards set by the Government, put all available workplaces at the disposal of the NLMB for the purposes of referral, and develop plans in conjunction with technical experts provided by the Board. Through these eligibility requirements, the Government influences the nature of workshops and the kinds of clients that are served without becoming involved at the operating level.

Currently there are three types of grants-in-aid for which workshops are eligible. For the construction of new facilities, the Government will pay 390 Swedish crowns per square meter (5 Swedish crowns equal $1), with an upper limit of 25 square meters per workplace. In certain special cases, this limit is extended to 40 square meters per workplace, but in all cases the number of workplaces in the shop is determined by the sponsor in conjunction with technical experts from the NLMB. In discussions with board staff members, I learned that in general this subsidy covers approximately one-half the costs of new construction. The remainder is covered by the sponsor, usually a municipality or a county. Office space is not covered by this grant; however, in rented premises, the subsidy is 125 Swedish crowns per square meter for renovation.

A second type of subsidy is available for the initial purchase of production equipment. The board estimated that this subsidy amounts to approximately 15,000 Swedish crowns per workplace on the average, but in theory there is no upper limit on the amount. Requests for this aid are reviewed by the board's technical experts and generally cover one-half of the purchase price of the equipment; in some cases, it can cover as much as two-thirds. Presently, the subsidy is applicable to the initial purchase of equipment only; no subsidies are available for replacement, change or purchase of additional equipment once the workshop has started operations.

A third type is available in the form of client wage subsidies. Workshops are reimbursed at the rate of 5,000 Swedish crowns for every 1,200 hours

of client work, or somewhat less than $1 per hour. For clients who have disability pensions or some other form of external support, the subsidy is paid at the rate of 3,000 Swedish crowns for every 1,200 hours worked. The Labor Market Board estimated that in 1970 a total in excess of $9 million was paid out to workshops in Sweden in the form of client wage subsidies.

One important characteristic of sheltered workshops in Sweden has been their rapid growth in the last 15 years. The rate of growth has been heavily influenced by government policy that is designed to encourage the establishment of new facilities. In 1955, for example, approximately 450 persons were employed in workshops, while at the end of 1965, the number had increased more than *ten* times, to approximately 5,000. And between 1965 and 1970, the total number served more than doubled again. This increase has not occurred in a vacuum. The VRD itself has experienced a rapid rise in the number of applicants for service during the same period. For example, between 1960 and 1970, the number of applicants for service increased from 33,486 to 87,901. Some experts feel that this number may increase beyond 100,000 by 1973.

Looking toward future arrangements and policy, Swedes are currently pondering the implications of this increase. This period of rapid expansion has led to a more widespread awareness in the society as a whole of the role of sheltered workshops, both in the service of the disabled and as an instrument of labor market policy. While many different sets of opinions are being offered, there appeared to me to be three basic schools of thought regarding the future role of workshops.

One school holds that workshops essentially isolate the disabled from "normal" society, therefore precluding the possibility of their assuming "normal" roles in the community. Hence they call for the development of alternatives to workshops as they currently exist. A second school advocates an immediate and vast expansion of workshop facilities, to the point where they could offer employment to a minimum of 100,000 persons. The third group favors the gradual expansion of workshop facilities concurrent with the development of alternative forms of employment.

Recently, and perhaps at least partly in response to some of the issues that have been raised by public discussion, a special government commission has been set up to investigate questions concerning the role of workshops in the future in Sweden. Among the questions being explored are what the optimal level of workshop services might be and what forms of administration and management might be most effective in insuring the viability of existing workshops. It has carried out an intensive study of workshops and is currently in the process of evaluating data and formulating proposals. The results of its work, which should be made public this year, will undoubtedly have a strong influence on government policy regarding workshops during the 1970's.

The principle which has guided the relationship between the NLMB and local workshops has traditionally been local autonomy in operation. The board itself does not operate facilities but does provide financial support and technical expertise. While in theory any individual, group or organization can sponsor a workshop, there are very few private sponsors, and their number is diminishing. The current trend, fully supported by the board, is for municipal or county, preferably the latter, sponsorship. There is growing sentiment that in order to insure the viability of existing workshops, methods for coordinating procedures and resources among them need to be developed.

The commission is exploring ways of "rationalizing" workshop operations through such means as joint purchase of materials, joint procurement of subcontract work, and cooperative efforts to train workshop managers and supervisory personnel. Clearly the development of such cooperative ventures is facilitated within counties when the county itself is the sponsor of all of the workshops within its borders. Clearly, too, there are questions about the implications of various methods of increasing "rationalization" and efficiency for just how centralized workshop operations are likely to become. These issues are being faced squarely by the commission.

Perhaps the most impressive aspect of the Swedish system of sheltered workshops in particular and vocational rehabilitation in general to me as an outsider was the willingness expressed by those involved to explore alternatives and to engage in public exploration of issues. While there has been very little research conducted on client reactions to various programs in comparison with that done in the U.S., a vast amount of information was available on program characteristics and costs. That this information was made readily available to a foreign researcher is evidence of the open-mindedness of the Swedes and their genuine interest in providing the greatest possible range of services and programs to their disabled populations.

Handle With Care. 16 mm. Black and white. 28½ minutes. National Medical Audiovisual Center (Annex), Station K, Atlanta, Ga. 30334.

This film combines documentary and dramatization to show what can be done to help mentally retarded children through community facilities.

Career Job Opportunity Series. National Audiovisual Center, General Services Administration, Washington, D.C. 20409. Attention Ralph Collett.

The series of 26 films are made available through the Department of Labor's Manpower Administration. Rental and purchase prices are available upon request to the National Audiovisual Center. Following is a list of the film titles and other pertinent information. All are 16 mm. sound motion pictures.

Applying for a Job. 11¼ min. Color. *Cooks, Chefs and Related Occupations.* 7 min. 10 sec. Color. *Business Machine Operators.* 6 min. 25 sec. Color. *Opportunities in Sales and Merchandising.* 11¼ min. Color. *MDTA-Manpower Development and Training Act.* 5 min. Color. *Jobs in Health.* 10½ min. Color. *Jobs in Small and Major Electric Appliance Repair.* 7 min. 10 sec. Color. *Drafting.* 6 min. 25 sec. Color. *Job Opportunities in Hotels and Motels.* 10½ min. Color. *Jobs in the Baking Industry.* 6 min. 30 sec. Color. *Jobs in the Sheet Metal Trades.* 9½ min. Color. *Opportunities in Clerical Work.* 9 min. 55 sec. Color. *Opportunities in Cosmetology.* 10 min. 8 sec. Color. *Opportunities in Welding.* 7 min. 11 sec. Color. *Jobs in the Automotive Trades.* 10 min. Color. *Opportunities in the Machine Trades.* 7 min. 10 sec. Color. *What's in it for Me?* 28½ min. Black and White. About job training. *At My Age.* 25 min. 28 sec. Black and White. Problems of older workers. Slanted for employment service counselors. *The Name of the Game.* 27 min. Black and White. Across-the-board portrayal of State and local public employment system services for hard-core unemployed and minority groups. *The Job Developer.* 10 min. 15 sec. Color. *The Counselor.* 15 min. 10 sec. Color. *The Work Supervisor.* 8 min. Color. *Neighborhood Youth Corps.* 7½ min. Color. *Pues, Alfredo?* (*Well, Alfredo?*) 26 min. Color and black and white. Aimed at Spanish American junior and senior high school students and veterans and designed to create awareness of the basic requirements and opportunities available in apprenticeship. *Skills for Progress.* 27 min. Color. Deals mainly with apprenticeships. *To Fill a Need.* 26 min. Color. About computers and "job banks."

The Physically Handicapped. Multi Media Office, Mount San Jacinto College, P.O. Box 248, Gilman Hot Springs, Calif. 92340. $12 each.

Four filmstrips are available. Each strip is accompanied by a tape, a worksheet, and a post-test. Tapes are available in both open reels and cassettes. Orders should specify the type of tape required. The filmstrips are:

Physical Handicaps and Learning (VT–1b) 45 frames. Tape 26 min. Introduces the vocational teacher to physiological factors affecting learning. Indicates reasons for vocational education involvement in training the physically handicapped, and suggests ways to learn more about the physically handicapped.

Making Vocational Education Accessible To The Physically Handicapped (VT–16c) 44 frames. Tape 20 min. An overview of accessibility factors affecting facilities and laboratory design—ranging from American National Standards to individual adaptations for achieving employability.

Employment Of The Physically Handicapped (VT–50a) 33 frames. Tape 17 min. Case studies which provide a perspective of current kinds and places of employment for the physically handicapped. Provides indications of what they can do, and suggests the need for broader employment opportunity.

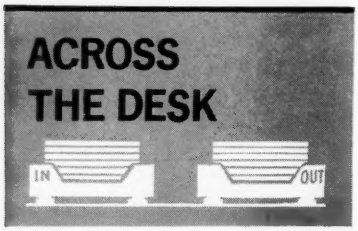
Teaching The Handicapped (VT–3b) 59 frames. Tape 22 min. An exploration of areas needing major attention in teaching the physically or mentally handicapped vocational students. Suggests the need for involvement to break the chain of events leading to educational handicaps.

What Do You Do When You See A Blind Person? 16 mm. Sound. 14 min. Public Education Division, American Foundation For The Blind, 15 West 16th St., New York, N.Y. 10011. Purchase, $75. Rental, $7.50.

The title of this film becomes its central theme. Phil, a sighted person, meets Jim, a blind person. Through the intermediary of the narrator, Phil turns his bumbling into correct procedure when he helps Jim to cross a busy New York street, in walking, talking, and dining. Phil soon learns that the "problems" of encounters with blind persons can be resolved by applying common sense.

I Think They Call Him John. 16 mm. Black and White. 26 min. Mass Media Associates, 2116 North Charles St., Baltimore, Md. 21218. Sale $175. Rental $17.50.

The emotional need of the elderly is underlined in this low-key film that follows John through a typical day of solitary nothingness. The narrator reminds us that "the old are an army of strangers" and that we have no intention of joining that army. But most of us will and the narrator asks: "If we don't care, who will learn to care?"



A NURSE, the 95th person to be chosen since 1900 and the 10th woman so honored, has been elected to the Hall of Fame for Great Americans at New York University. She is Lillian D. Wald (1867-1940) who founded the Visiting Nurse Service of N.Y.

WELL SAID; WORTH SAYING: While we don't cry with our patients, and while we do not rage with them--or at them--we do feel free to laugh with them . . . Something is wrong in a therapy where the patient and the therapist never laugh together. (Martin Grotjahn, M.D., in an article in Voices, Summer 1969, Journal of the American Academy of Psychotherapists) . . . . Since more than 90 percent of all institutionalized offenders are eventually released from confinement, the ultimate test of any correctional program cannot be made in the institution. It is made on the street. (From The Offender As An Educational Resource in Criminal Justice and Corrections, Research and Demonstration 3156, final report). . . . Though it is widely recognized and accepted that the disabled are disabled people rather than disabled people, remedial programs seem to focus more upon the latter. (Perception of Disability by the Non-Disabled by A. P. MacDonald and Janet Hall.)

ENZYME levels in the blood may prove to be an indicator of the ultimate survival of heart attack patients, according to a Philadelphia doctor. Blood tests on 125 consecutive patients with acute heart attacks turned up a striking correlation between the extent of the enzyme rise, the development of postcoronary complications, and survival. The doctor has discovered that patients with enzyme levels of three times or more above normal were in the most jeopardy. Damaged heart cells account for the excessive leaking of the enzyme into the circulatory system.

PUBLIC ASSISTANCE ROLLS in Arkansas should be reduced by 100 persons in the first year, 125 in the second, and 150 in the third, as the result of an expansion grant that will allow a cooperative program between the Division of Rehabilitation Services and the Division of Social Services. The project calls for the establishment of five strategically-located satellite units to prepare disabled public assistance recipients for employment. The units will be staffed by a rehabilitation counselor, a job placement specialist, a social service aide, a social services caseworker, and a secretary. The project is similar to new programs in several States. Data from the programs will be sent to the Regional Rehabilitation Research Institute, University of Florida for monitoring and evaluation on a national scale.

DIALOGUE MAGAZINE (3100 Oak Park Avenue, Berwyn, Ill.) has inaugurated a new series of short articles in which people without sight describe ways that they have found effective for meeting usual--or unusual--situations in their lives. Payment will be made for those accepted, on the magazine's customary basis. Anyone interested should address the magazine's Better Living Editor. Articles should not be longer than 700 words and should describe either a physical or philosophical solution used by the writer in solving some problems experienced because of blindness.

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REHABILITATION RECORD

The weakest ink is better than the strongest memory

contents

MARCH–APRIL 1972
VOLUME 13, NUMBER 2

	Page
Volunteerism: Reawakening To An Age-Old Truth Diane S. Roupe	1
Home Teaching Of The Adult Blind Herman Allwein	7
The State Of Blindness; Its Counselors of State; And Its Citizens Warren Bledsoe	11
Automation In The Health And Welfare Field John H. Noble	14
Black Students Prepare For Rehabilitation Careers In Speech Therapy Bruce M. Siegenthaler	20
Diagnosis, Retardation, and Deafness McCay Vernon and Edward Kilcullen	24
Wagner O'Day Act Amendments Michael M. Dolnick and William M. Usdane	30
Sheltered Workshops In Sweden John R. Kimberly	35

Features

New Publications, pages 18, 27 . . . Project Reports, page 28 . . . Program Notes, page 34 . . . Films on Rehab, page 39 . . . Across The Desk, page 40.

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